MEDICARE: AN INSIDE LOOK INTO THE INNER WORKINGS OF THE MEDICARE PROGRAM

What Every Medical Resident Needs To Know About The Medicare Program

DISCLAIMER

This handbook is designed to provide accurate and authoritative information with regard to the subjects covered, and every reasonable effort has been made to assure the accuracy of the information within these pages. However, the ultimate responsibility for correct coding/documentation lies with the provider of services.

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FIFTH EDITION - December 1999

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CHAPTER 1
OVERVIEW OF MEDICARE

Introduction

The purpose of this section is to introduce the Medicare program. Medicare is separated into three parts - Part A, Part B and Part C . This section describes the different types of beneficiaries eligible for Medicare Parts A, B and C and the various types of Medicare coverage your patients may be eligible for. A portion of this section is dedicated to explaining how the different branches of the Federal government affect the policies/payments of Medicare Parts A, B and C.

Common terms and Medicare acronyms appearing in this document will be explained in detail and include:

Common Terms:

- Medicare Part A
- Medicare Part B
- Medicare Part C
- Contractor
- Fiscal Intermediary
- Carrier
- Beneficiary

Medicare Acronyms:

- HCFA - Health Care Financing Administration
- CLIA - Clinical Laboratory Improvement Amendments
- EMC - Electronic Media Claims
- E/M - Evaluation and Management
- HIC - Health Insurance Claim Number
- CPT - Current Procedural Terminology
- HCPCS - HCFA Common Procedure Coding System
- ICD-9-CM - International Classification of Diseases
- MSP - Medicare Secondary Payer
- OCR - Optical Character Recognition
- UPIN - Unique Physician Identification Number
- RRB - Railroad Retirement Board

Overview

What is Medicare?

Medicare is a federal health insurance program which provides medical coverage for people 65 or older, for certain disabled people, and for some people with end-stage renal disease (ESRD). The program, which began July 1, 1966, was established by Congress through Title XVIII of the Federal Social Security Act. Medicare is managed by the Health Care Financing Administration (HCFA), which is a branch of the Health and Human Services (HHS) division of the U. S. Federal government. HCFA awards contracts to organizations called contractors to process claims for Medicare and perform related administrative functions (e.g., claims processing). HCFA provides operational direction and policy guidance for nationwide administration of the program.

How Big Is The Medicare Program?

In 1999, Medicare:

- processed more than 700 million claims;
- paid out more than $77 billion in benefits; and
- had 39 million beneficiaries receiving benefits.

What Is Medicare Part A?

Part A of the Medicare program is hospital insurance. This part of the program is financed by:

- taxes paid by employers and employees through the Federal Insurance Contributions Act (FICA);
- self-employed individual contributions through the Self-Employment Contributions Act; and
- railroad workers, their employers and representatives through the Railroad Retirement Act.

Organizations which administer Medicare Part A are called “fiscal intermediaries” (FI).

Part A coverage helps to pay for (not limited to):

- inpatient hospital care;
- inpatient care in a skilled nursing facility following a covered hospital stay;
- home health care; and
- hospice care.

What Is Medicare Part B?

Part B of the Medicare program is medical insurance. Financing for this part of the program is obtained from:

- premium payments by enrollees;
- occasional contributions from general revenues by the Federal government; and
- interest earned on the Part B trust fund.

Organizations which administer Medicare Part B are called “carriers.”

Part B coverage helps to pay for (not limited to):

- medically necessary doctors’ services provided in a variety of medical settings including, but not limited to, the physician’s office, an inpatient/outpatient hospital setting, rural health clinics and ambulatory surgical centers;
- charges from limited licenced practitioners such as: independently practicing physical/occupational therapists, licensed clinical social workers and clinical psychologists, certified registered nurse anesthetists, nurse midwives,

advanced registered nurse practitioners (ARNPs); physician's assistants (PAs); and audiologists;
- clinical laboratory and diagnostic services;
- surgical supplies and durable medical equipment; and
- ambulance services.

What Is Medicare Part C?

A Medicare beneficiary may choose to have covered items and services furnished to him/her through a managed care plan instead of the traditional Medicare Program. This coverage, referred to as "Medicare+Choice" or "Medicare Part C" is a new set of heath care options created by the Balanced Budget Act of 1997. This new option allows the Medicare beneficiaries more choices in health care and the contractors that serve them. Examples of Medicare+Choice providers include:

- Health Maintenance Organizations (HMO);
- Point of Service (POS) Option;
- Provider Sponsored Organization (PSO);
- Preferred Provider Organization (PPO) ;
- Medicare Medical Savings Account (MSA);
- Private Fee-For-Service Plan; or
- A Religious Fraternal Benefit Society Plan (RFP).

The Medicare Managed Care Plan must have a contract with the Secretary of Health and Human Services (HHS) in order to participate in the Medicare program as a Medicare Managed Care Plan. A Medicare Managed Care Plan must provide the same services which a beneficiary would be eligible to receive from Medicare if he/she was not a Managed Care Plan enrollee. In other words, the beneficiary is still technically "on Medicare", but has selected a different contractor and is required to receive services according to that contractor's arrangements. The beneficiary's entitlement to Medicare is based on the same criteria whether his/her health care expenses are payable by an HMO or traditional Medicare carriers and/or fiscal intermediaries. Medicare beneficiaries will be able to enroll or disenroll from a Medicare Managed Care Plan* at any time through the year 2001; however, beginning January 1, 2002 limits will be placed on when disenrollment can occur.

*The only exception is Medicare Medical Savings Accounts (MSA), for which he/she is "locked in" for a period of one year.

Who Is Eligible For Medicare?

There are three basic types of individuals who are eligible to be insured by Medicare. One becomes eligible based on one's own earnings, or on those of a spouse, parent, or child. A specified number of quarters of coverage (QCs) must be earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA). The exact number of QCs required for insured status depends on to which of the three basic groups the individual belongs:

- the aged;
- the disabled; or
- those with end-stage renal disease.

The effective date of Medicare Part B and Part C coverage depends on the month in which enrollment takes place therefore, the effective dates for Medicare Part A, Part B or Part C may be different.

Medicare Part B is a voluntary program for which the insured must pay a monthly premium.

Eligibility requirements have been established that must be met before the beneficiary would not be required to pay a monthly premium for Medicare Part A coverage (also known as premium-free HI). If the requirements for premium-free HI are not met, but the beneficiary is still eligible for Medicare and he/she wishes to have coverage under Medicare Part A, he/she must pay a monthly premium. It is estimated that less than 1% of current Medicare beneficiaries are paying a monthly premium for Medicare Part A coverage.

Some individuals are eligible for Medicare Railroad Retirement Benefits. The Railroad Retirement Board (RRB) will issue the Medicare card to individuals eligible for those benefits.

Getting to Know Your Medicare Patients

Who Are The Aged Insured?

An aged insured is 65 years old or older and is eligible for monthly Social Security or Railroad Retirement cash benefits, or equivalent Federal government benefits.

Premium-free hospital insurance becomes effective with the month in which the individual attains age 65 if he/she applies for the benefit within six months of his/her birth month. Age 65 is attained on the day before the 65th birthday, so an individual born on December 1 attains age 65 on November 30. Hospital insurance is effective November 1. Entitlement generally does not end until death.

Medicare medical insurance, since it is a voluntary program, becomes effective based on when the individual enrolls and begins to pay the monthly premium. If the beneficiary chooses not to enroll in Medicare Part B when he/she attains age 65, there are other specifically designated times in which he/she may enroll. If your patient has a question about, or has a problem regarding his/her eligibility to Medicare Part B benefits, have him/her contact the local Social Security office. An individual's coverage to Medicare hospital insurance may be terminated whenever any of the following occurs:

- a voluntary request; or
- end of entitlement to Medicare Part B for an aged insured; or
- non-payment of premium if beneficiary not eligible for premium-free HI; or
- death of the beneficiary.

An individual's coverage to Medicare medical insurance may be terminated whenever any of the following occurs:

- a voluntary request; or
- non-payment of premium; or
- termination of HI benefits; or
- death of the beneficiary.

Who Are The Disabled Insured?

An insured who is entitled to Social Security, Railroad Retirement, or equivalent Federal government benefits on the basis of disability is automatically entitled to hospital insurance (Part A) and is considered enrolled for Part B unless coverage was refused. The entitlement begins after the individual has been disabled for a total of 24 months. This type of entitlement is also available to a disabled widow, a widower, or a child of a deceased, disabled, or retired worker.

If an individual recovers from a disability, and the individual was not dually eligible for Medicare, entitlement ends in the month following notification of the disability termination. Medicare entitlement based on disability also terminates in any of the situations listed under *Who Are The Aged Insured?*

Who Are the End-Stage Renal Disease (ESRD) Insured?

Individuals of any age who receive dialysis or a kidney transplant for end-stage renal disease (ESRD) are eligible for HI (and are deemed enrolled for SMI unless such coverage is refused) if they file an application for benefits and they:

- meet certain work requirements for insured status under the social security or
- railroad retirement programs; or
- are entitled to monthly social security benefits or an annuity under the Railroad Retirement Act; or
- are spouses or dependent children of such insured or entitled persons.

Entitlement to Medicare usually begins after a 3-month waiting period has been served, e.g., with the first day of the third month after the month in which a course of renal dialysis begins. Entitlement can begin at an earlier date, as long as certain requirements are met.

Federal law mandates that Medicare is the secondary payer for claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (during a period of 30 months) except where an aged or disabled beneficiary had Group Health Plan (GHP) or Large Group Health Plan (LGHP) coverage which was secondary to Medicare at the time ESRD occurred. The 30 month period in which Medicare is the secondary payer is called the coordination period and it begins with the earlier of:

- the month in which a regular course of renal dialysis is initiated; or
- in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

Note: The Balanced Budget Act of 1997 extended the ESRD coordination period to 30 months from 18 months for any individual whose coordination period began on or after March 1, 1996. Individuals whose coordination period began before that date have an 18-month coordination period.

For patients who are eligible to Medicare solely based on ESRD, coverage ends with the earliest of the following dates:

- the day an individual dies;
- the last day of the 12th month after the month the course of dialysis is discontinued, unless the individual receives a kidney transplant during that period or begins another course of dialysis; or
- the last day of the 36th month after a person receives a kidney transplant. If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues. If a person whose entitlement based on ESRD has ended begins a new course of dialysis or has a kidney transplant, reentitlement begins without a waiting period.

Medicare entitlement based on ESRD also terminates in any of the situations listed under *Who Are The Aged Insured?*

Do Medicare Beneficiaries Have Any Special Rights?

As outlined in the 1999 version of the Medicare beneficiaries *Medicare & You* handbook, which published by the Health Care Financing Administration (HCFA) and sent to all Medicare beneficiaries, each Medicare beneficiary has certain guaranteed rights. These guaranteed rights are:

- protection when they get health care services;
- assured access to needed health care services;
- protection against unethical practices;
- the right to receive emergency care without prior approval;
- the right to appeal the original Medicare plan's decision about payment/services provided;
- the right to information about all treatment options;
- the right to know how their Medicare health plan pays its doctors; and

Section 4311 of the Balanced Budget Act of 1997 gives the beneficiary the right to submit a written request to their provider or supplier for an itemized statement for any Medicare item or service. The law also requires providers or suppliers to furnish the itemized statement within 30 days of the request. Failure to provide the statement within 30 days could result in a civil monetary penalty of up to $100.00 for each failure.

How Are Medicare Beneficiaries Identified?

When an individual becomes entitled to Medicare he/she receives a health insurance card which shows his/her name, sex, Medicare number, and the effective dates of his/her entitlement to hospital (Part A) insurance and medical (Part B) insurance. Both HCFA and the RRB issue Medicare cards.

The Medicare numbers issued by HCFA usually reflect the insured's Social Security number with an added letter or alpha/numeric suffix. In some cases, it is possible for the Medicare identification number to be different from the insured's Social Security number. Medicare numbers issued by the RRB may be the insured's Social Security number or a six-digit number. Regardless of the length of the number, the insured's number will always have an alpha prefix. The format of the HCFA-issued (non RRB) Medicare number is 000-00-0000 followed by a suffix. An example of this is 123-45-6789A. In this case, the "A" suffix stands for Wage Earner (Primary). If the wife becomes entitled to Medicare through her husband's contributions, she would receive a Medicare card with his Social Security Number with a "B" suffix.

The majority of your Medicare patients will be those whose eligibility is based on Social Security benefits. You can tell this by asking to see, and make a copy of their Medicare card. Failure to indicate the beneficiary's name and identification number exactly as it appears on the Medicare card may result in a claim delay/denial. You may also want to establish a process by which insurance information (e.g., the Medicare identification number) is verified at certain time intervals to insure that the information has not been changed. If a change has occurred, the patient's records will need to be updated to reflect the most current information.

Note: Due to an increase in lost and stolen Medicare cards, a photo ID is also suggested to insure that the patient is the same person who is eligible to receive the benefit. If it is determined that Medicare paid a claim for services rendered to a non-Medicare eligible beneficiary, a refund request may be generated.

What If My Patient Is A Member Of A Medicare Managed Care Plan?

Who Processes The Claims For A Medicare Managed Care Plan?

If your patient is a member of a Medicare managed care plan, the local Medicare Part B carrier cannot process the claims. The Medicare managed care plan is not considered responsible for paying the claims for their members unless the physician provides emergency services, urgently needed services, or other covered services not made reasonably available by the Medicare managed care plan, or unless you are affiliated with the Medicare managed care plan. When the physician submits claims for a beneficiary enrolled in a Medicare managed care plan, the local Medicare Part B carrier will deny payment for the services (except dialysis and related services provided in a dialysis facility), but will automatically transfer the claim to the appropriate Medicare managed care plan.

How Can I Receive Reimbursement If I Am Not A Medicare Managed Care Plan Provider?

If the claim is filed to the Medicare managed care plan, the physician may be reimbursed. However, if the Medicare managed care plan will not pay the claim, the physician has the right to file an appeal with the Medicare managed care plan or the Health Care Financing Administration (HCFA), or collect from the patient. If the claim is denied, the physician may collect his/her full fee for services rendered.

What If I Am Not A Medicare Managed Care Plan Provider?

If the physician is not a Medicare managed care plan provider, it is important that the physician emphasizes to his/her Medicare managed care plan patients what their financial liability will be. If they choose to continue to see you as their provider of choice for health care services, they will have a clear understanding of their out-of-pocket expenses that may be incurred.

Medicaid

The Medicaid program is a joint federal/state health care plan for beneficiaries that are not able to financially obtain health insurance. It was established by Congress in 1965 as part of the Social Security Act.

The Medicaid beneficiary receives either a Medical Identification Card (MIC), and an HRS-ES Form 2014 (Authorization for Medical Eligibility), or an HMO/PHP card. If the patient is eligible for both Medicare and Medicaid, the physician must send the claim to Medicare first. Medicare claims for physician services rendered to Medicare beneficiaries who are also entitled to Medicaid benefits must be submitted on an assigned basis (assignment will be discussed in chapter 3). To indicate the patient is entitled to Medicaid, the patient's Medicaid ID number should be entered in block 10d on the HCFA-1500 claim form (or in the equivalent field on the electronically filed claim)

For physicians who accept Medicaid assignment, the total Medicare and Medicaid payments represent payment in full for services rendered. In cases where Medicaid does not make payment for certain services based on program limitations, providers should follow Medicaid's guidelines for collection of these amounts.

Note: Medicaid assigns each physician a unique provider number (separate from his/her Medicare provider number) to bill for services to the Medicaid program. For more information about becoming a Medicaid provider, you may contact your local Medicaid office.

Railroad Retirement Beneficiaries (RRB)

Some Medicare Part B beneficiaries are eligible for Medicare Railroad Retirement Benefits. These beneficiaries are easily recognized because their Medicare number is either a six-or nine-digit number which begins with an alpha character rather than a numeric character. A RRB-issued HIC number is formatted as: 000000 or 000-00-0000 with an alpha prefix. Valid alpha prefixes are: A, H, CA, J, MA, MH, PA, PD, PH, WA, WD, WH, WCA, WCD, WCH.

Primary Railroad Retirement claims are sent to:

United Health Care
RRB Medicare Claims Office
P.O. Box 10066
Augusta, Georgia 30999-0001
Eastern Standard Time - Phone: (706) 855-1386
Central/Pacific Time - Phone: (706) 855-8441

When United Health Care is the secondary payer (secondary payer benefits are discussed in chapter 4), claims are sent to:

United Health Care
RRB Medicare Claims Office
P.O. Box 30304
Salt Lake City, Utah 84130-0404
Phone: (801) 523-6965

United Mine Workers of America (UMWA)

Some Medicare beneficiaries are members of the United Mine Workers of America (UMWA). The UMWA Health and Retirement Funds is a health benefit plan for retired UMWA coal miners, their spouses and dependents. Claims for the UMWA should be sent to:

UMWA Funds
P.O. Box 9224
Van Nuys, CA 91409

Durable Medical Equipment Regional Carrier (DMERC)

As part of HCFA's goal to increase program efficiencies, effective in 1994, all providers were required to submit most services for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims to the Durable Medical Equipment Regional Carrier (DMERC) responsible for processing DME claims in their region.
For a complete list of all procedures codes billable to the DMERC, please write to your local Medicare carrier or local DMERC.

Regional Home Health Intermediary (RHHI)

An RHHI processes claims for Part A hospice and home health care services. There are currently six RHHIs located throughout the United States. Medicare carriers are assigned based on the state in which the beneficiary lives. For the name of the carrier in your state, you should contact your local carrier. Additionally, this information is published in the 1999 *Medicare & You* handbook published by the Health Care Financing Administration.

What Are The Government Agencies That Affect Medicare?

State Agencies

For all Medicare Part A providers and certain Medicare Part B providers, a state agency (usually a component of the State Health Department) surveys and recommends to the Secretary of the Department of Health and Human Services (DHHS) whether providers and suppliers are eligible to participate in the Medicare program. The State agency's principal activities in this area include the following:

- identifying an institution or facility that might qualify as a provider or supplier for the Medicare program using guidelines provided by the Secretary;
- inspecting, certifying, and recommending to the Secretary whether the provider or supplier qualifies as a participating provider or supplier; and
- consulting with providers and suppliers to help them sustain their quality standards compliance.

Various state agencies are also charged with the responsibility for medical licensing of providers. For a list of state agencies that you need to contact regarding your particular specialty, contact your provider association or local government.

Various state, county and city agencies are also charged with the responsibility of issuing applicable business licenses, based on state, county and city law. For a list of applicable state, county and city agencies that you need to contact regarding the applicable business licenses that are required, contact your state and city government.

Federal Agencies

Congress

Congress is one of the deciding bodies that makes the decisions and passes the laws that affect how the Medicare program reimburses physicians and beneficiaries. There are several bodies within Congress that directly affect the rules and regulations within the Medicare/Medicaid program. They are:

House of Representatives:

- Ways & Means Committee;
- Appropriations Committee; and/or
- Energy & Commerce Committee

Senate:

- Appropriations Committee;
- Finance; and/or
- Energy & Commerce Committee

To keep informed about changes proposed by Congress to Medicare Parts A, B or C, the physician can get a breakdown of only the Medicare and Medicaid changes by subscribing to the Commerce Clearing House Guide to Medicare and Medicaid by writing to:

Commerce Clearing House, Inc.
4025 West Peterson Ave
Chicago, IL 60646

Department of Health And Human Services (DHHS)

The cabinet level agency responsible for Medicare is the Department of Health and Human Services (DHHS). The Secretary of DHHS contracts with private insurance companies to process Medicare claims. DHHS is responsible for conducting audits and investigations for the Federal Government regarding fraud and abuse.

Health Care Financing Administration (HCFA)

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare/Medicaid programs. The department is a body within the DHHS area of the government which creates policies and receives Congressional mandates for carriers/intermediaries to implement.

HCFA is divided into different regions or consortiums with one central office located in Baltimore, Maryland. The Central Office provides operational direction and policy guidance for the nationwide administration of the Medicare/Medicaid programs. Regional offices are located in: Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, Philadelphia, San Francisco, and Seattle. Each regional office provides policy guidance to several Medicare contractors.

Social Security Administration (SSA)

The Social Security Administration (SSA) is a part of the Federal government that insures that beneficiaries are eligible for Medicare benefits and signs them up for Medicare Part A and/or Medicare Part B, Medicare Travelers, Black Lung (The Funds program), or a Medicare+Choice plan. Once a patient is enrolled in the Medicare Program, the SSA will send them an enrollment package as well as a Medicare identification card.

In addition to other duties, the SSA is also responsible for:

- maintaining deductible status;
- replacing lost or stolen Medicare cards;
- address changes;
- maintaining and establishing beneficiary enrollment;
- collecting premiums from beneficiaries; and
- educating beneficiaries regarding coverage and insurance choices.

The Office of Inspector General (OIG)

The OIG, under the Department of Health and Human Services (DHHS), investigates suspected fraud or abuse and performs audits and inspections of HCFA programs. It helps protect the Medicare program by investigating suspected fraud or abuse and develops cases. It also has the authority to take action against individual health care providers in the form of civil monetary penalties (CMPs) and program exclusions and to refer cases to the Department of Justice (DOJ) for criminal or civil action.

The OIG has also been charged by the Secretary with the authority to exclude providers who have been convicted of a health care related offense.

The Peer Review Organization (PRO)

The Peer Review Organization (PRO) is an organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries. This organization is sometimes referred to as the Quality Improvement Organization (QIO).

The PRO also investigates patient complaints regarding quality of care received from physicians, hospitals, nursing homes, or Medicare health plans. The PRO handles appeals/requests from Medicare patients regarding a review or reconsideration of a denied hospital stay.

In Summary:

- Beneficiaries can have multiple types of insurance instead of, or in addition to, Medicare Parts A, B or C.
- Medicare eligible beneficiaries have certain protections and rights.
- There are several government agencies which affect the rules and regulations which govern the Medicare program.

CHAPTER 2
BECOMING AND BEING REIMBURSED AS A MEDICARE PROVIDER

Introduction

This section explains how a physician becomes a Medicare provider, discusses assignment, outlines the benefits of the Medicare Part B participation program, highlights how the Resource Based Relative Value Units affects Medicare reimbursement, describes payment incentives and explains how non-participating limiting charges affect your practice.

How Do I Become A Medicare Part B Provider?

The Medicare/Federal Health Care Provider/Supplier Enrollment Application (HCFA-855) is the enrollment form issued by HCFA. Any provider and supplier that want to be paid by Medicare must complete and submit the HCFA-855. The HCFA-855 form is used to collect general information about a provider or supplier and to secure documentation to ensure that the applicant is qualified and eligible to enroll in the Medicare program.

The completed HCFA-855 form should be sent to your local carrier's provider enrollment department for review. The provider enrollment department is responsible for verifying the information and the attached documentation. If the verification process results in the issuance of a provider number, the applicant will be notified accordingly. The notification will include the provider's unique Medicare billing number, which should be utilized in all communication with the local carrier.

If you would like to obtain a copy of the HCFA-855, please notify your local carrier's provider customer service area or provider enrollment department.

Who Can Enroll In Medicare Part B?

Physician Services

The Medicare program defines a physician as: a doctor of medicine or osteopathy; a doctor of dental surgery or dental medicine; a chiropractor; a doctor of podiatry or surgical chiropody; or a doctor of optometry, legally authorized to practice by a state in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.

The issuance by a state of a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local standards are used in determining whether a particular physician has legal authorization. If the state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Residents/Interns -General

For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or graduates of foreign medical schools who do not have a valid medical license. When a senior resident has a staff or faculty appointment or is designated, e.g., a "fellow," it does not change the resident's status for the purposes of Medicare coverage and reimbursement.

As a general rule, services of interns and residents are paid as provider services by the intermediary. Except for the services furnished by interns and residents outside the scope of their training program (see B below), the following types of services performed by interns and residents are reimbursable to the hospital under Part B on a reasonable cost basis:

- services by interns and residents not in approved training programs;
- services performed for hospital outpatients;
- services of kinds which would otherwise be covered under Part A but for which the patient is not eligible under Part A (e.g., he has used up his days of inpatient hospital benefit eligibility).

A. Services Furnished by Interns And Residents Within The Scope of An Approved Training Program

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. This includes services furnished in a setting which is not part of the non-provider facility, where a hospital has agreed to incur all or substantially all of the costs of training in the non-provider facility. The physician is required to notify the Medicare carrier of such agreements. Where the physician does not incur all or substantially all of the training costs and the services are performed by a licensed physician, the services are reimbursable on a reasonable charge basis by the carrier.

B. Services Furnished by Interns And Residents Outside The Scope of Their Training Program

The Medicare program reimburses for medical and surgical services furnished by residents and interns that are not related to the interns' or residents' training program and that

are performed in an outpatient department or emergency room of a hospital. Such services may be covered as "physicians" services, reimbursable on a reasonable charge basis, but only where the following criteria are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contributes to the diagnosis or treatment of the patient's condition;
- The intern or resident is fully licensed as a physician for purposes of performing the services; and
- The services are performed under the terms of a written contract or agreement and can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns and residents. The Medicare carrier is expected to review the contracts/agreements for such services to assure compliance with the above criteria.

How Are Providers Categorized?

Providers are added to the Medicare Part B system based on their credentials or specialties. There are many specialties recognized within the Medicare program. Physicians may have a primary, as well as a sub-specialty. Since a physician's specialty may be used to determine peer utilization comparisons, it is important that you notify the carrier of the predominate specialty of your practice that you would like noted on Medicare records . There is no payment differential applied to a service based on specialty.

How Are Providers Identified?

Providers receive several different numbers which are used to identify them:

- Provider Identification Number (PIN)
- Unique Physician Identification Number (UPIN)

What Is A Provider Identification Number (PIN)?

The Provider Identification Number (PIN) is your individual provider number issued by your local Medicare carrier. This number allows you or the patient to receive reimbursement for claims that are filed to the Medicare carrier. The format of the PIN is unique and varies from carrier to carrier. Because a PIN is required on all Medicare claims filed to the carrier, failure to indicate your individual PIN in the appropriate paper claim block or electronic claim field will result in a denial as an "unprocessable" claim.

What Is A Unique Physician Identification Number (UPIN)?

The Unique Physician Identification Number (UPIN) is an alpha/numeric six-digit number for the Medicare provider. All providers must obtain a UPIN even though they may never bill Medicare directly.

One UPIN is assigned to each provider, regardless of the number of practice settings. The UPIN stays with the provider throughout his/her Medicare affiliation, regardless in which state they practice. The UPIN is used by HCFA to aggregate payment and utilization information for individual providers, to ensure compliance with carrier/intermediary recommendation for sanctions, to validate duplicate services submitted to multiple insurances (Part A/B), and to ensure location.

When Is A UPIN Required?

A UPIN is required if the service is requested by a:

Referring Physician - A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician - A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services or durable medical equipment.

What Services Require A UPIN?

The UPIN requirement will be based on the type of service provided, not the provider's specialty.
Presently these include:

- consultation services;
- most diagnostic services including laboratory and radiology services;
- durable medical equipment and other medical supplies;
- orthotic/prosthetic devices, including optical supplies;
- services by independently practicing physical or occupational therapists; and/or
- routine foot care.

How Do I Enter The UPIN On The Claim?

When entering the HCFA assigned UPIN of the referring/ordering physician, the UPIN must be indicated in block 17a and the name of the referring physician must be in block 17 of the HCFA-1500 form. This same information is required when filing the electronically transmitted claim. Multiple referring and/or ordering physicians, require a separate claim for each ordering/referring physician service.

What If I Do Not Have A UPIN?

If you are the ordering/referring physician and have not been assigned a UPIN, a surrogate UPIN must be used.
All surrogate UPINs, with the exception of retired physicians (RET000), are temporary and may be used only until an individual UPIN is assigned. Surrogate UPINs require the physician's address in addition to the physician's name and are monitored for misuse by carriers. A surrogate UPIN consists of three alpha characters followed by three zeros.

Examples of ordering/referring physicians who may require the use of a surrogate UPIN are:

- **RES000** = Resident
- **VAD000** = Physicians serving on active duty in the military of the United States and those employed by the Department of Veteran's Affairs.
- **PHS000** = Physicians serving in the Public Health Service, including the Indian Health Service.
- **RET000** = Retired physician
- **OTH000** = When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for using one of the above listed surrogate UPINs, the biller may use the surrogate UPIN OTH000 until an individual UPIN is assigned.

What If No Referring Physician Exists?

When performing services that require a UPIN and no referring physician exists, report the UPIN and name of the performing physician.

What Is The Real Difference Between A PIN And A UPIN?

- PINs are the numbers the physicians use to receive reimbursement/bill for services.
- UPINs are never used as billing provider numbers and are only used when a service requires a referring/ordering physician.

What Is A Solo Practitioner?

A solo practitioner is defined as a provider who wants to bill Medicare and:

- incurs his/her own overhead expense; and
- is free from the administrative overhead of a corporation/multiple member association.

If you choose to file claims to Medicare as a solo practitioner, you may request an individual PIN for billing. Each local carrier issues their own PIN so numbers will vary in format depending upon the carrier. This PIN makes you a unique individual when filing services to the local Medicare carrier.

The address tied to the PIN will generally be the physician's billing/mailing address and may be different from the physician's physical address. Most carriers can maintain two addresses on the provider address file if you do not want your checks to come to your street address. As a new provider, Medicare may verify your address through several means, including contacting the post office or by a personal visit.

What Is A Physician Association (PA) Group Practice?

A PA group is defined as a partnership, association or corporation composed of two or more physicians and/or non-physician practitioners who wish to bill Medicare as a unit.

If you choose to file claims as part of a PA group, the group must request a group PIN number for billing. Each local carrier issues their own PA group PINs, so numbers will vary in format depending upon the carrier. This group PIN will make your group unique when filing services to your local carrier.

The address tied to your group PIN will generally be your billing/mailing address and may be different from your physical address. Most carriers can maintain two addresses on your provider address file if you do not want your checks to come to your street address. If you are forming a new group, Medicare may verify your address through several means, including contacting the post office or by a personal visit.

Reassignment of Benefits: Each member within the group must complete a reassignment of benefits form stating that they agree to turn all monies over to the group. After the reassignment agreement has been signed, your local Medicare carrier will tie your individual physician PIN to the group PIN. When the group bills Medicare, they will need to use this provider number when filing for services you perform as part of the group.

How Do I Request or Change A PIN, Add A New Member to My Group, Obtain A UPIN or Change My Address?

When requesting a provider number, adding members to a group, or changing your address, send your request to your Medicare carrier's provider enrollment department. This department will send you one of the standard HCFA-855 forms.

The Participation Program

What Is Participation?

Participation in the Medicare program means a provider voluntarily enters into an agreement to accept assignment for all services provided to Medicare patients, thereby becoming a participating provider. If you are a participating physician or supplier, you must accept assignment of Medicare benefits for all covered charges for all patients. A provider who chooses not to participate (called a non-participating provider) can still accept assignment of Medicare claims on a case-by-case basis.

What Are The Different Types of Claims That Can Be Filed?

A claim or request for Medicare payment is filed to the Medicare Part B carrier as either assigned or non-assigned. A provider may never charge a Medicare patient for completing or filing a claim.

What are assigned claims?

When a physician files an assigned claim to the Medicare Part B carrier, the reimbursement is sent directly to the provider. You agree to accept the Medicare fee schedule amount as payment in full for all covered services and will only collect non-covered services, any unmet deductible and any co-pay amount from the beneficiary.

Assignment is not automatic on a claim. You must check the appropriate block (27) of the HCFA-1500 (12-90) claim form or the applicable electronic claim field to accept assignment of Medicare benefits for that claim. While the provider can be non-participating with the Medicare Part B carrier, he/she can still accept assignment on a particular claim.

If you choose to file the claim assigned, you are held to the assignment agreement, for that claim only, and cannot collect more than the Medicare fee schedule amount for the covered Medicare Part B service, as well as your established fee for any non-covered services, any unmet deductible and any co-pay amount from the beneficiary.

What are non-assigned claims?

Non-assigned claims are claims that are filed to the Medicare Part B carrier for reimbursement to be sent directly to the patient/beneficiary. Non-assignment is not automatic on a claim. You must check the appropriate block (27) of the HCFA-1500 (12-90) claim form or the applicable electronic claim field to indicate that you are not going to accept assignment of Medicare benefits for that claim. Only a non-participating Medicare provider can file a claim non-assigned.

If you are a non-participating physician, you have a choice to file a claim assigned or non-assigned. If you choose to file the claim non-assigned, you may only collect from your patients up to the limiting charge (discussed at the end of this chapter) of a covered Medicare Part B service, as well as your established fee for any non-covered services.

When Can The Decision To Participate Be Made?

Toward the end of each calendar year (generally in November), all Medicare carriers have an open enrollment period. During this period, providers can change their current participation status for the next calendar year. This is the only time providers are given the opportunity to change their participation status.

A participation package is sent to each active Medicare provider during the open enrollment period. This package normally contains information about:

- the advantages of participating;
- Medicare fee schedule allowances for the next calendar year;
- proposed legislative changes which could impact the participation decision;
- the providers current participation status and year of practice for new physicians (if applicable); and
- the Participating Provider Agreement Form.

The agreement form need not be completed and returned to Medicare if a provider does not wish to change his/her participation status for the next year.

Can I Change My Participation Status?

The participation period lasts for one year (from January 1 to December 31), and once you have signed a participation agreement, it is very unlikely that a decision to change participation status during the year will be honored by Medicare. A provider who would like the change his/her participation status during the year would need to notify the local carrier's provider enrollment department and specifically state the reason for the change.

Always remember, if you are already a participating provider, it is not necessary to sign another participation agreement. The current participation status will remain in effect until the carrier is notified otherwise.

What Are The Benefits of Participation?

- **Eligibility Access** - Participating providers who submit claims electronically have access to beneficiary eligibility files via a vendor access. See the EMC section for additional information regarding this enhancement.

- **Financial** - The Medicare fee schedule allowances are about 5% higher for participating physicians. In addition, physicians who participate are not subject to limits on their actual charges.

- **MEDIGAP** - Participating providers can take advantage of the Medigap benefit.

- **MEDPARD Directory** - Carriers maintain a toll-free telephone line which allows Medicare beneficiaries to request information about participating providers in their area. Some carriers maintain MEDPARD directories on their web site or Bulletin Board System (BBS).

If you need more information about the participation program, please write to your local Medicare Part B carrier.

The Non-Participating Physician:

- is held to a "limiting charge" when submitting non-assigned claims;
- must file all Medicare claims for potentially reimbursable services on behalf of his/her Medicare patients;
- may collect up to their limiting charge at the time the services are rendered; and
- is reimbursed a Medicare fee schedule allowance which is 5% lower than a participating physician.

Reimbursement

How Does Medicare Part A Reimbursement Work?

Medicare Part A claims are reimbursed on a cost-based fee. This means the reimbursement is based on the Medicare Part A provider's cost - negotiated with their fiscal intermediary (FI). This reimbursement methodology includes services provided by:

- home health agencies;
- hospitals;
- nursing homes;
- rural health clinics; and/or
- skilled nursing facilities.

The FI reimburses Part A inpatient hospital care at a predetermined rate per discharge in accordance with the Diagnosis Related Group (DRG) to which the discharge is assigned and at a Federal standardized payment amount. These rates are payment in full for inpatient operating and capital costs. Beneficiary cost sharing is limited to deductibles, coinsurance and non-covered items and services.

How Does Medicare Part B Reimbursement Work?

Medicare Part B reimbursement is based on an established "fee-for-service" for certain services filed to the carrier. The services included in this pricing are:

- physician services;
- clinical laboratory;
- Durable Medical Equipment (DME); and
- injectibles.

Medicare Part B providers are reimbursed 80% of the lower of either the established fee schedule, reasonable charge or customary (depending on the type of provider) or their billed charge for the following services:

- physician services;
- DME;
- ambulance; and
- diagnostic tests.

Some services are reimbursed at 100% of either the established fee schedule or their billed charge (whichever is lower) for the following services:

- clinical laboratory;
- influenza or pneumococcal vaccinations; and
- other exceptions as defined by HCFA.

How Was The Medicare Part B Physician Fee Schedule Developed?

Payment for "physician" services is based on a fee schedule which prices services based on three key components commonly known as the **Resource Based Relative Value Units (RBRVUs**). The RBRVU system establishes a national value for each procedure code. The RBRVU for a service will be the sum of the relative value units associated with:

- the physicians work which includes the time, intensity and technical skill required to render a service;
- practice overhead expenses such as rent, office staff salaries, office supplies, etc.; and
- malpractice insurance premiums.

Geographic Practice Cost Indices (GPCIs) - GPCI relative value units allow for variations in practice costs between geographic areas and are established locally. A GPCI is established for each RBRVU component (work, overhead and malpractice) in each of the pricing localities for a given state.

National Conversion Factor (CF) - This is a national number that is used by all Medicare Part B carriers to calculate the physician fee schedule. Services are calculated using a single CF. CFs are ultimately determined by Congress each year and take into account an anticipated rate of inflation, differences in projected against actual claims volumes, Medicare enrollment changes and other factors which might impact the overall Medicare Part B budget.

What Is A Capitation Rate?

A capitation rate is a set amount paid by HCFA to a managed care plan selected by each enrolled Medicare beneficiary. This agreed upon amount is paid to the plan which in turn reimburses the physician for services provided within the terms of the agreement/plan, regardless of the cost/amount of care provided to each Medicare beneficiary enrolled in the managed care plan.

What Can I Collect From My Patients?

On assigned claims, the Medicare beneficiary is responsible for:

- any unmet deductible;
- non-covered services; or
- any applicable co-insurance amounts.

On non-assigned claims, the Medicare beneficiary is responsible for:

- for the entire billed up to, but not to exceed the limiting charge for most services provided by a non-participating physician. If you would like to obtain a fee schedule book, which outlines the current year Medicare physician fee schedule amounts, including the limiting charge information, contact your local Medicare carrier.

What Is A Deductible?

Like most other insurance plans, Medicare Parts A & B have deductibles that must be satisfied prior to the carrier/intermediary making a payment. The deductibles and co-insurance amounts are a cost/shared dollar amount applicable to covered services/supplies.

The **1999 Part B deductible** is applied to each beneficiary's plan on an annual basis and is currently **$100.00.**

The **1999 Part A deductible** is applied every benefit period as follows:

- 1-60 days (if there is a break in an inpatient stay) = **$768.00 per each 60 day benefit period.**

Additionally, a Medicare Part A beneficiary has lifetime reserve days as follows:

- 61 - 90 days = $192.00 per day;
- each non-renewable, lifetime reserve day = $384.00 per day;
- skilled nursing facility coinsurance (after first 20 days) = $96.00 per day.

Providers must collect the unmet deductible from the beneficiary. Consistently waiving the deductible could be construed as program abuse. If the beneficiary is unable to pay, the provider should have them sign a waiver outlining their financial hardship. If no waiver is signed, the beneficiary's medical record should reflect that there were normal/reasonable* attempts to collect from the patient prior to writing-off the charge.

*Normal/reasonable is defined as applying your normal collection processes to Medicare as well as non-Medicare patients. For example, if you normally call the patient and send two written notices before referring them to collection agencies, you must do the same with your Medicare patients.

What Is Coinsurance?

The beneficiary or the beneficiary's supplemental insurance company is responsible for paying the provider the co-insurance amount that Medicare will not pay.

Co-insurance amounts are generally 20% of the Medicare fee schedule. Providers must collect the unmet co-insurance from the beneficiary. Routine waiver of co-insurance could be construed as program abuse. If the beneficiary is unable to pay, the provider should have them sign a waiver outlining their financial hardship. If no waiver is signed, the beneficiary's medical record should reflect that there were normal/reasonable* attempts to collect from the patient prior to writing-off the charge.

*Normal/reasonable is defined as applying your normal collection processes to Medicare as well as non-Medicare patients. For example, if you normally call the patient and send two written notices before referring them to collection agencies, you must do the same with your Medicare patients.

What Is Supplemental Insurance?

Supplemental insurance or coverage is an insurance policy purchased by a Medicare beneficiary to help pay for those services which Medicare does not cover, such as: deductibles, coinsurance, non-covered services, etc.

Some supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the Medicare program to send Medicare claim information to them electronically. When no automatic crossover occurs, the beneficiary must file his/her own supplemental claim. Traditional supplemental insurance policies reimburse the patient directly and the patient is responsible for reimbursing the health care provider.

Some crossover exclusions include:

- date(s) of service outside of the patient's eligibility period;
- claims paid at 100 percent of Medicare approved amount; and
- Medicare claims which contain totally denied services.

What Is MEDIGAP?

MEDIGAP is a privately offered, Medicare-supplemental health insurance policy available to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts or other limitations imposed by Medicare.

Under the OBRA 1987 provision on MEDIGAP, the Medicare carrier is required to crossover any Medicare claim for services rendered by a participating provider (physician or supplier) when the beneficiary has reassigned these benefits. The MEDIGAP insurer is then required to pay any supplemental benefits directly to the provider. The reassignment of these benefits is made on a claim by claim basis and requires signed authorization from the beneficiary.

The Medigap process is a added benefit to the participating physician. This crossover process eliminates the need for the beneficiary or provider to file a separate claim to the beneficiary's supplemental insurer. By submitting a single

Medicare claim which includes accurate Medigap insurer policy information as well as the beneficiary's signed authorization, the provider receives both the Medicare and co-insurance amounts. When billing for MEDIGAP claims, it is important to remember:

- MEDIGAP policy information must be accurately reported on the Medicare claim.
- The reassignment of supplemental Medigap benefits can be made only to participating Medicare providers.
- The beneficiary must sign authorization for the reassignment of Medigap benefits.
- Claims are crossed over on a claim–by–claim basis.

Are There Any Additional Financial Incentives I Need To Know About?

Medicare has a special financial incentive in place to provide you with additional reimbursement and ensure that Medicare beneficiaries located in rural areas have access to health care. This special incentive is available in health professional shortage areas located throughout the United States.

What Is A Medicare Part B Health Professional Shortage Area (HPSA)?

A Health Professional Shortage Area (HPSA) is an area of the state which has been designated as a medically under served area. HPSAs may cover an entire county or only a portion of a county or city, and are defined as either rural or urban HPSAs.

HPSA Terms/Descriptions:

- **Claim Filing Requirements -** Physicians should indicate that their services were rendered in an eligible HPSA area by using the appropriate modifier:

QB Physician service rendered in a **rural** HPSA; or
QU Physician service rendered in an **urban** HPSA.

- **Eligibility -** The service must be rendered in a HPSA county or a portion thereof.

- **HPSA Territories** - The portions of counties eligible for incentive payments are defined by census tracts. Your Medicare carrier should be able to define the designated HPSA's in your local area.

- **Method of Payment -** Payment is determined and issued on a quarterly basis for both assigned and nonassigned claims for physician designated services. The HPSA incentive payment is 10% of the amount Medicare paid to the provider in the last quarter. A summary explanation accompanies each quarterly incentive check.

- **Providers Applicable** - For the purpose of this provision of the law, only physician services are eligible for HPSA payments and are further defined the following providers types: M.D.s, D.O.s, D.C.s, D.P.M.s, D.D.S.s and O.D.s.

Are There Any Limits on What I Can Charge My Medicare Patients?

The limiting charge represents the maximum amount that a nonparticipating physician can legally charge a Medicare beneficiary for services billed on **nonassigned** claims. Such limits are not applicable to charges from participating physicians, nor for any services billed on an assigned basis by nonparticipating physicians.

How Are Limiting Charges Calculated?

The limiting charge can be no higher than 15% above the fee schedule amount for nonparticipating physicians (i.e., 115%). The limiting charge may be rounded to the nearest dollar if done so consistently for all services. The following formula should be used when rounding:

$.01-$.49 round down, $.50-$.99 round up.

Where Can I Find Limiting Charges?

Each year a fee schedule allowance booklet is mailed to all active Medicare physicians. In this booklet, your Medicare carrier has calculated the Medicare allowances for each procedure code for both participating and nonparticipating physicians. The fee schedule book also includes the limiting charges for non-assigned claims.

Are There Any Exceptions To The Limiting Charge Rules?

Generally, all services reimbursed under the physicians fee schedule are subject to the limiting charge. Some common exceptions are:

- services that are never covered by Medicare;
- durable medical equipment (DME);
- prosthetics/orthotics;
- technical components of diagnostic tests;
- independent physiological laboratories (IPLs);
- portable x-ray companies;
- independent laboratories; and
- ambulance services.

Are Beneficiaries Notified of Limiting Charges?

Yes. The patient is notified on their Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) of their liability and alerts them to any excess billed amounts which must be refunded to them.

In Summary, How Does Medicare Part B Reimburse Me For My Services?

The following illustrates basic reimbursement by Medicare Part B according to a provider's participation status and/or whether assignment is accepted:

Participating Provider Always Must Accept Assignment:

A. Submitted charge = $125.00
B. Medicare allowed (participating fee schedule) amount = $100.00
C. Medicare pays physician 80% = $80.00
D. Patient is billed for 20% coinsurance = $20.00
E. Provider can collect the 20% coinsurance amount or $20.00 from the patient.

Non-Participating Provider Who Does Not Accept Assignment:

A. Submitted charge (Medicare limiting charge) =$109.25
B. Medicare allowed (non-participating fee schedule) amount = $95.00
C. Medicare pays patient 80% of fee schedule = $76.00
D. Provider can collect up to limiting charge (A) from patient **= $109.25**

Non-Participating Provider Who Does Accept Assignment:

A. Submitted charge = $125.00
B. Medicare allowed (non-participating fee schedule) amount = $95.00
C. Medicare pays provider 80% of fee schedule = $76.00
D. Patient is billed for 20% coinsurance = $19.00
F. Provider can collect the 20% coinsurance amount or $19.00 from the patient.

Note: A provider may bill the beneficiary for all services that are exclusively NON-COVERED by Medicare, any unmet deductible, and the 20% co-insurance if the claim is not subject to the Medigap provisions on assigned claims..

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CHAPTER 3
TYPES OF CLAIMS/FILING METHODS

Introduction

This section introduces the various types of Medicare claims that can be filed. Specific electronic field claim requirements as well as block-by-block HCFA 1500 claim instructions can be obtained by contacting your local Medicare Part B carrier. You also may access the Medicare on line training web site at: *www.medicaretraining.com*. This web site contains a computer based training module designed to help you become familiar with the HCFA-1500 claim form and the requirements for each field.

Types of Claims

The proper completion and submission of a "clean" Medicare Part B claim is the first step in insuring your claim is processed as expediently as possible. A "clean" claim is one that has been properly completed and submitted, and therefore does not require requests for additional information from the provider before the claim can be successfully processed.

Assigned Claims:

As mentioned in Chapter 2, assigned claims are filed to the Medicare Part B carrier with reimbursement being sent directly to the provider.

Certain services, when rendered, may only be paid on an assigned basis:

- clinical diagnostic laboratory services;
- physician services to individuals dually entitled to Medicare and Medicaid;
- services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists and clinical social workers;
- Ambulatory Surgical Center (ASC) facility charges; and
- home dialysis supplies and equipment paid under Method II.

Non-Assigned Claims:

Non-assigned claims are claims that are filed to the Medicare Part B carrier for reimbursement to be sent directly to the patient/beneficiary.

Methods of Submission

Claims can be filed to the Medicare Part B carrier one of two ways:

- by electronic transmission; or
- by filing a paper claim.

The physician may choose to electronically submit his/her Medicare claims directly from his/her office. If you have a computer system which meets the requirements, you could be issued a sender number and submit your claims directly from your office. This would place the timeliness and accuracy of the claims directly under the physician's control. If you do not have a computer, you can choose and pay a billing service to submit your claims. When claims are filed electronically, there are certain processing requirements as well as benefits associated with this form of transmission.

Electronic Media Claims (EMC)

Electronic Media Claims (EMC) is a submission process by which Medicare Part B claims are electronically transmitted by telephone lines, via a modem, to the Medicare Part B carrier. EMC filing gives the provider control over the timeliness and accuracy of the claims entry by eliminating the need for mail room processing and manual data entry by Medicare Part B claim processors. Payment is released from the Medicare Part B system as soon as the Health Care Financing Administration (HCFA) time frame requirements for claims payment have been satisfied. This results in a quicker cash flow turnaround for providers. In fact, payment for electronic claims is made 14 days after the date of receipt of the transmission, opposed to 27 days for paper claims.

Submitting claims electronically will result in an overall cost savings for the provider. These cost savings occur because purchase costs for paper claims and postage costs for mailing them are eliminated, coupled with the quicker claim processing time. For more information about how to become an electronic claim filer, call or write to your local Medicare carrier.

How Electronic Media Claims (EMC) Works

Claims data is transmitted, via a modem, over the telephone lines to the carrier's modem. Most carriers allow electronic claims to be transmitted seven days a week.

The carrier's modem converts the data and transmits it to a computer system. Once the Medicare Part B claims are received, they are electronically checked (or edited) for the correct information. Claims that pass these edits, called front-end or pre-edits, are then processed according to Medicare policy and guidelines. Claims that do not pass the initial edits, due to the submission of incomplete or inadequate field information, are rejected.

Rejected claims are not processed because they lack the adequate information needed to make a payment decision. Rejected claims are transmitted back to the sender, who must make the necessary corrections before the claim can be processed by Medicare. Once these claims are corrected, they can be refiled (electronically) to the Medicare carrier.

An acknowledgment or confirmation report/listing indicating the number of claims received and total charges submitted is transmitted back to the sender's computer. This confirmation

report/listing assures the sender that Medicare has successfully received their transmission.

After the claim has processed (whether paid or denied), a remittance notice is generated to the provider.

Front-End Edits and Development

When the Medicare Part B processing system receives an electronically submitted claim, a process occurs in which the system checks for valid and/or missing information in each field which has a specific field edit requirement.

This process is called a "front-end" edit. A claim will be rejected if during this initial edit, it is found to have incorrect, invalid or missing information. Rejected claims are not processed by the carrier because they lack the adequate information needed to make a payment decision. Rejected claims must, therefore, be corrected and electronically retransmitted or mailed back to the carrier for processing.

A rejected claim data file, which identifies the missing or invalid information for the claim(s) rejected, is sent back to the sender. This may be sent electronically or on a paper listing, depending upon the sender office and the carrier.

Occasionally, claims require additional information (in addition to front-end edit information) before they can be finalized. A development letter requesting submission of the missing information is mailed to the provider and/or beneficiary. Based on the response for the additional information, the claim is processed. Failure to respond to this additional development request may result in denial of your claim.

Certificates of Medical Necessity (CMN)

Claims submission software that complies with the National Standard Format (NSF) enables the provider to take advantage of additional functions such as Certificates of Medical Necessity (CMNs). CMNs give the provider an opportunity to electronically submit medical documentation. CMNs may be utilized when submitting claims for the following types of services: ambulance, cataract glasses, chiropractor, durable medical equipment (DME), oxygen and certain types of podiatry services.

Note: All carriers neither utilize nor require the use of CMNs. You should check with your local carrier to see if a CMN is required for the services you provide.

Carrier Software

Most Medicare contractors offer software products, at a very affordable rate, which allow providers the opportunity to transmit electronic claims from their offices directly to their Medicare carrier.

Additional EMC Benefits

In addition to the day-to-day benefits of electronic claims submission, EMC senders may also take advantage of these other features.

- **Eligibility Access:** Participating providers who have their claims filed electronically have access to beneficiary eligibility files, via a vendor access. By giving you access to your patient's Medicare eligibility file, you can determine whether the patient is eligible for Medicare benefits; has met his/her Medicare deductible; is enrolled in a health maintenance organization; or is entitled to Medicare under the Medicare Secondary Payer provision.

- **Electronic Remittance Notification (ERN):** This feature allows the EMC provider to receive paid and/or denied claims information electronically from the Medicare Part B system. ERN can be utilized to automatically update providers' accounts receivable or patient billing system. ERN is equivalent to the Medicare Remittance Notice (MRN) form and can eliminate the need to post payments manually.

- **Electronic Claims Status (ECS):** EMC providers can obtain a listing of all their pending claims (claims that are 14 days old or older) in the Medicare Part B system. This is a convenient way for the provider to track and monitor claims (paper or electronic).

- **Electronic Funds Transfer (EFT):** Whether you are an electronic or paper sender, EFT provides the capability of electronically sending Medicare Part B payments directly to the provider's financial institution.

Filing The HCFA 1500 Claim Form

Medicare Part B paper claims may be filed using only the red printed HCFA-1500 (12/90) claim form. This form is appropriate for filing all types of health insurance claims to private insurers, as well as government programs. The time frame requirements for payment of paper claims are substantially longer than for electronically submitted claims. All "clean" paper claims must be paid 27 days after the date the claim is received by Medicare Part B, as opposed to 14 days for electronically submitted claims.

How Paper Claim Submission Works

Physicians must complete all mandated claim fields on the HCFA-1500 claim form, and then mail their paper claims to their local carrier. All information should be typed or machine-printed. At some carrier sites, the claims are processed using Optical Character Recognition (OCR) equipment. OCR is an automated scanning process that reads the information submitted on claim forms, much as the scanners in grocery stores read price labels. With OCR, claims processing is faster and more accurate than those requiring manual intervention. After the information on the claim is captured, it is sent into the claims processing

system, where it is validated and compared to other data until the final processing activities occur. For OCR to work correctly, the scanner must accurately read and interpret the characters entered in each field of the HCFA-1500 claim form, which was designed and printed using a special red ink that the scanner cannot read. It reads only the information that has been typed or machine-printed onto the HCFA-1500 claim form. To insure accurate, quick claim processing, follow these guidelines:

- Do not staple, clip, or tape anything to the HCFA-1500 claim form;
- Place any necessary documentation in the same envelope as the HCFA-1500 claim form;
- Put the patient's name and Medicare number on each piece of documentation submitted;
- Use dark ink;
- Use only upper-case (CAPITAL) letters;
- Use 10 or 12 pitch (pica) characters and standard dot matrix fonts;
- Character fonts may not be mixed on the same form;
- Italics and script may not be used;
- Old or worn print bands or ribbons should be avoided;
- Do not use dollar signs, decimals or any punctuation in fields on the claim form;
- Enter all information on the same horizontal plane within the designated field;
- Extraneous data may not be printed, handwritten, or stamped on the form;
- Corrections may be made with lift-off correction tape only;
- Insure information is in the appropriate field and does not overlap into other fields;
- Pin fed edges should be removed at side perforations; and
- Use only original red and white HCFA-1500 (12-90) claim forms.

The forms are available as a single sheet, two-part snap-out, one-part continuous, or two-part continuous form. The carrier does not supply the HCFA-1500 claim form, but they can be purchased from either local printers or by contacting:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402
or
American Medical Association (AMA)
P.O. Box 10946
Chicago, IL 60610

The Government Printing Office sells negatives for printing the forms. They may be ordered from:

Assistant Superintendent of Departmental
Account Representative Division
U.S. Government Printing Office Room C-830
Washington, D.C. 20401

Understanding The Remittance Notice

Upon completion of processing your claim in the Medicare system, you will receive a remittance notice which will provide you with details on your finalized claim. Each service submitted on your claim will contain detailed information which explains the Medicare allowed and paid amounts, and any deductible or denial information applicable to that service.

In addition to the provider notices, Medicare beneficiaries also receive either a Medicare Summary Notice (MSN), Explanation of Medicare Benefits (EOMB), or Notice of Utilization (NOU), dependent on which carrier or intermediary processes their claim.

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CHAPTER 4
MEDICARE SECONDARY PAYER (MSP)

Introduction

The following section describes how claims are handled for beneficiaries who do not have Medicare Part B as their primary source of insurance. There are some Medicare eligible beneficiaries who choose to continue their employment after they are eligible for Medicare benefits. In this situation, their medical services must be filed to their employer primary insurance company first and then to Medicare Part B. The Medicare program refers to this type of coverage as *Medicare Secondary Payer.*

Medicare Secondary Payer Regulations

Medicare Secondary Payer (MSP) is the Medicare program's coordination of benefits with other insurers. The MSP program was initiated in 1980 to protect the Medicare funds as well as ensure that Medicare does not pay for services which are reimbursable under any private insurance plan or other government program. Medicare cannot pay for any item or service which has been, or can reasonably be expected to, be filed to another insurance company prior to Medicare payment.

When is Medicare Considered Secondary?

When services are paid by:

- Worker's Compensation;
- Working Disabled;
- No-Fault or liability insurance plan;
- End Stage Renal Disease;
- Working Aged;
- Veterans Administration;
- Black Lung program.

A patient's eligibility coverage could change at any time during the course of treatment. Therefore, you should question your Medicare patients on an ongoing basis to determine if any of these MSP conditions apply to them.

How To Determine When Medicare Is The Secondary Payer

Medicare identifies a beneficiary for secondary payment when information provided indicates there **may** be other primary insurance involvement. This information may come from claims submitted to Medicare where other insurance involvement has been indicated or if the Social Security Administration (SSA) provides Medicare with this information. Sometimes, other insurance carriers notify Medicare that there is other insurance involvement. In any of these instances, the beneficiary's entitlement records are identified as having other insurance primary to Medicare. Future claims are then processed according to the Medicare Secondary Payer (MSP) guidelines.

Do Limiting Charges Apply to A Medicare Secondary Payment?

The Social Security Act Amendments of 1994 explicitly prohibit a non-participating provider who does not accept assignment, from billing or collecting amounts above the applicable limiting charges, regardless of who would be responsible for the payment. Therefore, you are encouraged not to exceed your Medicare limiting charge when billing a claim to another insurer, prior to filing the non-assigned claim to Medicare Part B. The provider may never charge a Medicare patient more than the limiting charge whether the claim is filed primary or secondary.

Does The Mandatory Assignment for Clinical Laboratory Apply to Claims Filed to Other Insurers?

The mandatory rules for assignment apply when sending a claim to Medicare whether the claim is filed primary or secondary.

Do I Have to File A Claim to Medicare If The Primary Insurer Pays More Than Medicare Allows?

Although it is not mandatory, carriers encourage you to send in a claim for secondary benefits. Unmet deductible amounts can be posted to the Medicare deductible even though no secondary payment amounts may be allowed.

In addition, the secondary payment is based on the higher of the primary insurer or the Medicare allowed amount. Therefore, Medicare may make a secondary payment even if the payment by the primary insurer is more than Medicare's allowed amount.

When Does Medicare Make A Conditional Payment?

Conditional payments are generally made in conjunction with liability cases. Medicare pays primary with the condition that once the liability case is settled, the Medicare program will recoup from the settlement the amount it rewarded.

In liability cases, a participating provider has the choice of billing Medicare, filing a claim, or billing the liability insurer directly for payment. If the provider bills Medicare first, the provider must file an amended claim or an adjusted bill with the liability insurer for non-covered services, deductibles or coinsurance only as required by Medicare Law. The provider cannot bill for the difference between its charge and the Medicare primary payment. This is double billing and is a violation of Medicare participation agreements.

If the provider bills Medicare first and the total bill is denied (e.g., non-covered diagnosis) the provider is not required to resubmit the bill. It is as if he/she had never billed Medicare at all. The provider is free to bill the liability insurer directly or to file a claim against the settlement proceeds for the full charge.

If Medicare denied part of the bill, the provider may bill the liability insurer for the full charges for all services that Medicare denied. This is not considered double billing. In the first case, no payment was made by Medicare. In the second case, Medicare paid for some services but not for others. Therefore, a provider is entitled to bill the liability insurer for any services not paid by Medicare.

On the other hand, if a provider decides to bill the liability insurer or file a claim against settlement proceeds instead of billing Medicare, the provider is entitled to pursue its full charges. The provider must wait 120 days after billing the liability insurer before requesting a conditional primary payment from Medicare. Once the provider bills Medicare for a conditional primary payment, the provider must amend its claim and/or adjust its bill to the liability insurer for non-covered services, deductible and coinsurance only. To do otherwise is double billing.

Providers must decide to which insurer they should submit their bill to first. Under no circumstances should Medicare and the liability insurer be billed at the same time.

Do Medicare Deductibles Apply to MSP Claims?

Expenses that serve to meet the beneficiary's Medicare Part B deductible (if Medicare were primary payer) are still applied to the deductible even if the primary insurer paid the entire bill and there is no Medicare secondary benefits due. The Medicare Part B deductible is applied on the basis of Medicare allowable charges, rather than the amount paid by the primary payer.

Are There Any Situations When Medicare Will Not Make Secondary Payment?

Generally, no secondary payment will be made for services covered by a Medicare HMO, VA (unless VA benefits will not be filed), Workman's Compensation, United Mine Workers, or Federal Black Lung (unless the condition is unrelated to the black lung disease).

How Do I Tell Medicare About An MSP Overpayment/Refund?

If Medicare processes and pays a claim as the primary insurer and it should have been processed as a MSP claim, a refund of the overpayment must be made to the carrier. To expedite the refund process, include the following with your refund:

- the primary insurer's payment sheet;
- type of primary insurance [e.g., Large Group Health Plan (LGHP), Auto]
- Medicare's remittance notice; and
- a check for the amount overpaid.

How Can I Help My Patients Update Medicare As A Primary Payer?

If your patient has difficulty restoring Medicare as a primary payer, you may need to assist him/her in obtaining the information required by the Medicare carrier. Information a carrier will need may differ based on the type of insurance. Carriers require that all information about the patient's primary insurance must be provided by the Medicare patient. Patients may call or write to their local Medicare carrier to update their file.

Some information must be documented in writing before Medicare can update the patient's records. You or your patient should contact your local Medicare carrier to determine if the information should be documented in written form or can be taken over the telephone.

Medicare as The Primary Insurer Questionnaire:

Questions for the patient to answer:

Use these questions to help identify other insurance payers which may be primary to Medicare. Beginning with Part 1, ask the patient each question in sequence. Comply with any instructions which follow an answer. If the instructions direct you to go to another part, have the patient answer, in sequence, each question under the new part. There may be situations where more than one insurer is primary to Medicare e.g., Black Lung and Large Group Health Payer. Be sure to identify all possible insurers.

Retain a copy of completed admission questionnaires in your files for audit purposes to demonstrate that development for other primary payer coverage takes place. It is not necessary that the completed questionnaire be signed by the beneficiary.

Part I

1. Are you receiving Black Lung (BL) Benefits?

   ❑ no

   ❑ yes; Date benefits began: CCYY/MM/DD

   _____

   BLACK LUNG IS PRIMARY ONLY FOR CLAIMS RELATED TO BLACK LUNG.

2. Are the services to be paid by a government program such as a research grant?

   ❑ no

   ❑ yes; GOVERNMENT PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

   ❑ no

   ❑ yes; DVA IS PRIMARY FOR THESE SERVICES.

4. Was the illness/injury due to a work related accident/condition?

   ❑ no; Go to Part II.

   ❑ yes; Date of injury/illness: CCYY/MM/DD

   _____

   Name and Address of WC plan:

   _____

   _____

   Policy or identification number:

   _____

   Name and address of your employer:

   _____

   _____

   WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

PART II

1. Was illness/injury die to a non-work related accident?

   ❑ no. GO TO PART III.

   ❑ yes; Date of accident: CCYY/MM/DD

   _____

2. What type of accident caused the illness/injury?

   ❑ automobile

   ❑ non-automobile

   ❑ other

   Name and address of no-fault or liability insurer:

   _____

   _____

   Insurance claim number

   _____

   NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

3. Was another party responsible for this accident?

❑ no. GO TO PART III.

❑ yes;

Name and address of any liability insurer

_____

_____

Insurance claim number

_____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

Part III

1. Are you entitled to Medicare based on:

❑ Age. GO TO PART IV.

❑ Disability. GO TO PART V.

❑ End Stage Renal Disease. GO TO PART VI.

Part IV - Age

1. Are you currently employed?

❑ no. Date of retirement: CCYY/MM/DD

_____

❑ yes;

Name and address of your employer:

_____

_____

2. Is your spouse currently employed?

❑ no. Date of retirement: CCYY/MM/DD

_____

❑ yes;

Name and address of spouse's employer:

_____

_____

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, UNDER PART IV ABOVE, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

❑ no. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

❑ yes;

4. Does the employer that sponsors your GHP employ 20 or more employees?

❑ no. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

❑ yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

_____

_____

Policy identification number

_____

Group identification number

Name of policy holder

Relationship to patient

Part V - Disability

1. Are you currently employed?

❑ no. Date of retirement: CCYY/MM/DD

❑ yes;

Name and address of your employer:

2. Is a family member currently employed?

❑ no.

❑ yes;

Name and address of employer:

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTION IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

❑ no. STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

❑ yes;

4. Does the employer that sponsors your GHP, employ 100 or more employees?

❑ no. STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTION IN PART I OR II.

❑ yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

Policy identification number

Group identification number

Name of policy holder

Relationship to the patient

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

❑ no. STOP. MEDICARE IS PRIMARY

❑ yes;

Name and address of GHP:

Policy identification number

Group identification number

Name of policy holder

Relationship to the patient

Name and address of employer, if any, from which you receive GHP coverage:

2. Have you received a kidney transplant?

   ❑ no.

   ❑ yes; Date of transplant: CCYY/MM/DD

3. Have you received maintenance dialysis treatments?

   ❑ no.

   ❑ yes; Date dialysis began: CCYY/MM/DD

If you participated in a self dialysis training program, provide date training started: CCYY/MM/DD

4. Are you within the 30 month coordination period?

   ❑ no. STOP: MEDICARE IS PRIMARY.

   ❑ yes.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

   ❑ no. STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

   ❑ yes;

6. Was you initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

   ❑ no. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

   ❑ yes; STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

   ❑ no; MEDICARE CONTINUES TO PAY PRIMARY.

   ❑ yes; GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

Hard copy questions and responses may be retained on paper, optical image, microfilm, or on microfiche. Hard copy and data must be kept for at least ten years, in accordance with the Department of Justice's (DOJ's) record retention requirements, after the date of service which appears on the claim. (See §480 for information about the documentation to be used in a hospital review.)

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE. (SEE §142.3F.) THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

When Does Medicare Ask for MSP Information?

Medicare will request MSP information from the beneficiary in several instances. According to Medicare guidelines, a letter requesting MSP information is sent to all Medicare beneficiaries when their **first** claim is filed to Medicare.

Medicare must send the questionnaire to the beneficiary to determine whether primary benefits can be paid by another insurer. Since the beneficiary (or the beneficiary's legal representative) is the only person who can advise Medicare of other insurance involvement, it is imperative that a **completed** questionnaire is returned. Providers may assist beneficiaries in completing the questionnaires. They must be returned to your Medicare carrier's Medicare Secondary Payer Department.

How Can I Get My Claim Reprocessed?

Claims denied by Medicare due to other insurance involvement may be reprocessed if there is no other insurance primary to Medicare. In such cases, providers may instruct the beneficiary to contact Medicare Part B to have the beneficiary's eligibility records updated. The beneficiary may call the Medicare Part B Beneficiary Customer Service Area, where the information can be easily taken by telephone. Alternately, the beneficiary may write to the Medicare Secondary Payer Department. Once the beneficiary has contacted the Medicare office, the beneficiary's file will be updated and all claims involved will be reprocessed. Until this information is updated on the beneficiary's file, subsequent claims may continue to be denied payment.

Note: Some information must be documented in writing before Medicare can update the patient's records. You or your patient should contact your local Medicare carrier to determine if the information should be documented in written form or can be taken over the telephone.

What Happens When the Beneficiary's Eligibility Records Are Updated?

Once it is established that a beneficiary is not covered by other insurance, several things will happen:

- The beneficiary's file is updated by SSA to reflect Medicare as primary payer;
- All pending claims awaiting a response for MSP information are released for processing; and,
- All claims denied based on suspected Medicare Secondary Payer involvement will be reprocessed.

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CHAPTER 5
MEDICARE PART B POLICIES AND REIMBURSEMENT

Introduction

This section is designed to introduce you to the various types of covered and non-covered services Medicare Part B processes, as well as legislative laws which have an effect on claims filed to the Medicare Part B carrier.

Overview

In general, the Medicare program is designed only to provide payment for services which are considered to be medically reasonable and necessary to the overall diagnosis and treatment of a patient's condition. This means for every service billed, the provider must indicate the specific sign, symptom or patient complaint necessitating the service.

While a service or test performed may be considered good medical practice, the Medicare program prohibits reimbursement of services absent of symptoms or complaints. Such services are generally considered screening services* or routine/preventive in nature and are non-covered.

***Note:** Medicare allows specific routine screening tests such as pap smears, routine screening mammogram services, colorectal cancer screening services, etc. Please refer to the "Project Prevention" section of this chapter for details.

Medicare Part B Physician Services

Physicians' services mean the professional services performed by a physician(s) for a patient including diagnosis, therapy, surgery, and consultation. A service may be considered to be a physician's service when the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc. For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service.

Professional services of the physician are covered if provided within the United States, and may be performed in the office, in a hospital or other facility setting, in the patient's home, at the scene of an accident or any other location. A patient's home is considered anywhere he/she makes his/her residence, e.g., a home for the aged, a nursing home, a relative's home, etc.

General Physician Services Covered By Medicare Part B

Covered physician services are (but not limited to):

- medical and surgical services (including anesthesia);
- diagnostic tests and procedures;
- radiology and pathology services;
- treatment of mental illness;
- drugs and biologicals that cannot be self-administered;
- transfusions of blood and blood components;
- medical supplies such as DME; and/or
- physical/occupational/speech therapy.

General Coding Guidelines For Medicare Part B Claims

The detailed field-by-field instructions for completing a HCFA-1500 (12-90) claim form can be obtained by contacting your local Medicare Part B carrier or you may access the Medicare Education and Outreach web site at: *www.medicaretraining.com*. This web site contains a computer based training module designed to help you become familiar with the HCFA-1500 claim form and the requirements for each field. However, there are specific coding requirements which must be met when submitting a claim to Medicare Part B.

All Medicare carriers process claims using the American Medical Association (AMA) coding structure referred to as Current Procedural Terminology (CPT) and the Health Care Financing Administration's Common Procedure Coding System (HCPCS). These coding publications are updated annually in January.

- A CPT code is a five digit numeric code which accurately describes the physician's service. For example, **an electrocardiogram, routine ECG with at least 12 leads; with interpretation and report** would be coded as **93000**.

- A HCPCS code is a five digit alpha/numeric code which accurately describes physician/non-physician services. For example, a B-12 injection would be coded J3420 (for the cost of the drug.)

Each procedure or service you provide to your patient and submit to the carrier must be identified by using either a CPT or HCPCS code. The CPT or HCPCS code is reported in block 24d of the HCFA-1500 claim form or the designated electronic formatted field.

The next most important element of coding is to accurately report your patient's diagnosis, symptom or complaint coded to the highest level of specificity. A diagnosis is submitted to the carrier by using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-

CM). ICD-9-CM codes are updated on an annual basis.

- An ICD-9-CM code is a three to five digit numeric or alpha-numeric code which describes the patient's diagnosis/ symptoms and documents the condition for which the test or service was ordered/provided to the patient. Up to four ICD-9-CM codes can be reported in block 21 of the HCFA-1500 claim form or the designated electronic formatted field.

For example, if a patient has a reported condition of diabetes mellitus, without mention of complication, TYPE II, stated as uncontrolled, the physician must code this condition to the highest level of specificity available in ICD-9-CM. The physician would report ICD-9-CM code 250.00 to describe this patient's condition.

Diagnoses must be referenced on the patient's Medicare claim utilizing a single digit numeric reference code (1, 2, 3, or 4), for each service submitted by the provider. Each one-digit numeric reference code is reported in block 24e of the HCFA-1500 claim form or the designated electronic formatted field. These indicators reference the diagnosis codes reported in block 21 of the HCFA-1500 claim form or the designated electronic formatted field. Multiple diagnoses can be submitted on a single claim which allows the physician to match the specific diagnosis code reported to the corresponding service that was provided to the Medicare patient.

ICD-9-CM diagnosis codes not coded to the highest possible level of specificity will cause a claim to be denied. The claim should be corrected and resubmitted as a new claim. A patient may not be billed for any service if the physician fails to code the diagnosis to the highest level of specificity.

Modifiers (CPT and HCPCS)

Modifiers are two digit alpha/numeric codes used in conjunction with a CPT or HCPCS code. Modifiers give a new or different meaning to a procedure code. The use of a modifier may increase or decrease the reimbursement allowed for a given procedure code or may merely be used as an informational reference. A modifier can never be submitted as a stand alone code. Modifiers and their descriptors are included in both the CPT and HCPCS publications.

For example, to report a professional component only of a chest x-ray **(Radiologic examination, chest; single view, frontal),** the physician would bill CPT code **71010** with modifier **26** which indicates **(professional component)**.

Places of Service Codes

The Medicare program utilizes a two-digit (11= office) numeric place of service coding structure. The place of service identifies the location where the item was used or the service was performed. A place of service is required for all services and is reported in block 24B of the HCFA-1500 claim form or in the designated electronic formatted field. Place of service codes may differ depending upon other types of insurance carriers.

Rules on Some Common Physician Services

Concurrent Care

Concurrent care exists when certain evaluation and management services are rendered by more than one physician on the same date of service. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, due to the existence of medical condition(s) requiring diverse specialized medical services.

In order to determine whether concurrent physicians' services are reasonable and necessary, the carrier must decide:

- whether the patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis; and

- whether the individual services provided by each physician are reasonable and necessary.

Before determining payment, carriers consider the specialties of the physician(s) as well as the patient's diagnosis.

The specialties of the physicians are an indication of the necessity for concurrent services, but the patient's condition and the inherent reasonableness and necessity of the services, as determined by the carrier's medical staff, must also be considered. For example, although cardiology is a sub-specialty of internal medicine, the treatment of both diabetes and of a serious heart condition might require the concurrent services of two physicians, each practicing in internal medicine but specializing in different sub-specialities.

On occasion, a patient may require the services of two physicians in the same specialty or sub-specialty when one physician has limited his/her practice to a unique aspect of that specialty. If it is determined that the services of one of the physicians is not warranted based the patient's condition, payment may be made only for one physician's services.

The carrier must also assure that the services of one physician do not duplicate those provided by another, e.g., when the patient's primary care physician visits the patient post-operatively where no documented medical necessity exists.

Consultations

A consultation is distinguished from a visit because it is done at the request of a referring physician and the consultant prepares a report of his/her findings which is provided to the referring physician for his/her use in the treatment of the patient. If the intent is to see the patient and give advice or opinion, then the consultation codes should be used.

A consultation report must contain documentation of the three key (history, exam and medical decision making) components of an evaluation and management service.

The need and the request for advice or opinion must be documented in the patient's medical record. The consultant's opinion/advice and any services/tests performed should also be documented and communicated back to the requesting (referring) physician.

The consultant may initiate diagnostic treatments and/or therapeutic services. However, when the consultant assumes responsibility for the patient, consultation codes should no longer be utilized. Depending upon the place of service, the consultant should begin using the appropriate established or subsequent evaluation and management codes.

Confirmatory consultations may be requested by the patient and/or family member or may result from the second or third opinion required by the patient's insurance.

Report separately, any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

Follow-up consultations should only be billed if:

- a second visit is required to render an opinion or advice; or
- a request for another consultation to the same physician is required during the same hospitalization.

All consultation codes (except confirmatory consultations) billed to Medicare must contain the UPIN of the referring physician.

Documentation requirements for consultations must include:

- the history, examination and the medical decision making components to support the level of care billed;
- a written report, which is furnished back to the attending (referring) physician for inclusion in the patient's permanent medical record; and
- a statement in the requesting physician's record on the advice or opinion being sought.

Payment For Teleconsultations In Rural Health Professional Shortage Areas

Effective January 1, 1999, Section 4206 of the Balanced Budget Act (BBA) provides for coverage and payment for teleconsultations in rural health professional shortage areas. Modifier GT (via interactive audio and video telecommunication systems) has been created to be used when reporting these services. For purposes of this benefit, interactive telecommunication systems means multimedia communications equipment that permit real-time consultation between the consultant and the referring practitioner and the beneficiary. Telephone, fax machines and electronic mail systems do not meet this definition.

Beneficiaries will be eligible for teleconsultation services if the site of the presentation is within a rural health professional shortage area. The beneficiary must be present during the time of the teleconsultation. As defined in 1842(b)(18)(C) of the Act, eligible consultants include: physicians (includes both M.D.s and D.O.s); physician assistants (through their employers); nurse practitioners; clinical nurse specialists; and nurse midwifes.

Only the following types of providers may bill as the referring physician: physicians (includes both M.D.s and D.O.s); physician assistants; nurse practitioners; clinical nurse specialists; nurse midwives; clinical psychologists; and clinical social workers.

Registered nurses and other medical professionals are not permitted to act as consultants during the telecommunication presentation. All nonphysician practitioners must accept assignment on claims billed for teleconsultations.

The teleconsultation must result in a written report by the consulting physician and must be furnished to the referring physician.

Medicare payment for teleconsultations cannot exceed the Medicare Physician Fee Schedule allowance for the consulting physician. Payment for telephone line charges and facility fees associated with teleconsultation are not reimbursed separately.

Only the consulting provider should submit a claim for the teleconsultation service. The consultant must provide to the referring physician 25% of any payments he or she receives for the consultation, including any applicable deductible or co-insurance amounts.

Diagnostic Tests - Purchased or Personally Performed

Diagnostic tests are services, such as x-rays, EEGs, cardiac monitoring and ultrasound. Purchased tests are services which are not rendered personally by the physician or by a physician's employee under his direct supervision. Tests administered by supplier personnel, whether at the

physician's office or at another location, are considered purchased tests. The fact that a physician has a financial interest in the supplier, perhaps as a limited partner or stockholder, does not change this consideration.

There are five situations that can occur when billing for diagnostic tests:

- global billing;
- technical component only;
- professional component only;
- purchased technical component; and
- purchased professional component.

Global Billing

This category of tests includes situations when you perform the test and interpret the results. When you bill globally you must have either: (1) personally performed both the professional and the technical components; or (2) personally performed the professional component and supervised your own employees who performed the technical component.

Technical Component Only

This category includes situations when you perform the test but do not interpret the results. You should submit the appropriate procedure code to Medicare using modifier TC.

Professional Component Only

This category of tests includes situations when you only interpret the test but do not perform the test. You should submit the appropriate procedure code to Medicare using **modifier 26 (professional component)**.

Purchased Technical Component

When the technical component is purchased from an outside supplier, it must be submitted separately from your professional component. Purchased technical services are identified by use of modifier WU and must include the Medicare provider number, name and address of the supplier that rendered the test. You must also indicate the amount you paid the supplier for the test. Failure to provide all of the required information will result in denial of the service. If more than one supplier is used or more than one test is purchased, separate claims must be submitted.

Purchased Professional Component

When the professional component (interpretation) of a diagnostic test is purchased from an independent physician or medical group, the service will only be reimbursed if:

- the tests are initiated by a physician or medical group which is independent of the person or entity providing the tests/interpretations;
- the person or entity requesting payment submits a claim; and
- the physician or medical group providing the interpretation does not see the patient.

The supplier must identify the physician name and Medicare provider number who provided the interpretation in both the paper and electronic designated claim fields.

For **all** purchased services, you must provide to the carrier the acquisition cost (how much you paid for the service). The acquisition cost needs to be reported in block 20 of the HCFA-1500 claim form or the designated electronic formatted field. Failure to complete this block/field will result in a denial.

Note: Remember to indicate the UPIN of the ordering physician on all claims for diagnostic tests.

EKG and X-Ray Interpretations

When there is a need to provide a medically necessary x-ray or EKG to a patient in the emergency room, the following guidelines apply:

- Payment will be made for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient.
- Hospitals are encouraged to work with the medical staff to ensure that only one interpretation charge is submitted per service. If the hospital physician's repeat reading is for quality control and/or liability purposes only such services are included in the Part A reimbursement payment.

Injections/Drugs/Biologicals

Medicare Part B processes claims for injections based on the type of drug injected. Basically, excluding influenza, pneumococcal and hepatitis B vaccines, there are three types of injection claims:

- covered injections provided as the only service to the patient;
- covered injections provided during the course of an evaluation and management service; and

- non-covered injections provided to the patient.

When a covered injection is the only service provided to a patient, the physician should bill:

- the CPT code for the administration; and

- the HCPCS (JXXXX) code for the drug.

If the injection is billed during the course of a covered evaluation and management service, the physician should bill:

- the CPT code for E/M service; and

- the HCPCS (JXXXX) code for the drug

Note: If a non-covered injection is provided to a patient, both the drug and the administration of the drug are non-covered items.

Psychiatric Services

Psychiatric services and/or evaluation and management services, rendered in the office or outpatient setting, which contain ICD-9-CM diagnosis codes (290-310) is reimbursed at 62.5% of 80% of the Medicare Physician Fee Schedule amount for the service provided. Inpatient psychiatric services are reimbursed at the routine 80% of the Medicare fee schedule amount.

Preventive Services

Preventive medicine has been addressed by:

- Congress as an area of focus to insure patient health, thereby reducing Medicare program expenditures; and

- HCFA as an opportunity to involve the provider community not only in the treatment of Medicare beneficiaries, but also to enlist physicians' help in educating the public regarding the benefits and coverage policies for certain preventive immunizations and screening procedures.

Bone Mass Measurements

Section 4106 of the Balanced Budget Act of 1997 (PubLNo 105-33) standardizes coverage of bone mass measurements by providing for uniform coverage for services provided on or after July 1, 1998. Bone mass measurement is a radiologic or radioisotopic procedure or other procedure: (1) performed with a bone densitometer (other than dual photon absorptiometry (DPA)) or a bone sonometer (e.g., ultrasound) device that has been approved or cleared for marketing by the Food and Drug Administration (FDA); (2) performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss or determining bond quality; and (3) includes a physician's interpretation of the results of the procedure.

The term "qualified individual" means an individual who meets the medical indications for at least one of the five categories listed below:

- a woman who has been determined by the physician or a qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
- an individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;
- an individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone, or greater, per day for more than 3 months;
- an individual with primary hyperparathyroidism; or
- an individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

Coverage criteria for bone mass measurements are as follows:

- are ordered by the individual's physician or qualified non-physician practitioner treating the beneficiary following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual;
- are furnished by a qualified supplier or provider of such services under at least the general level of supervision of a physician;
- are reasonable and necessary for diagnosing, treating, or monitoring a "qualified individual" as defined above; and
- are performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the FDA for bone measurement purposes, with the exception of DPA devices.

Medicare may cover a bone mass measurement for a beneficiary once every 2 years (if at least 23 months have passed since the last bone mass measurement was performed). However, if medically necessary, Medicare may cover a bone mass measurement for a beneficiary more frequently than every 2 years. Examples of situations where more frequent bone mass measurements may be medically necessary include, but are not limited to, the following medical circumstances:

- monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months; and
- allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, Medicare will

allow coverage of baseline measurement using bone densitometry.

The following CPT codes existed prior to the implementation of the BBA of 1997:

- **76075 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)**
- **76076 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)**
- **76078 - Radiographic absorptiometry (photodensitometry), one or more sites; and**
- **78350 - Bone density (bone mineral content) study, one or more sites; single photon absorptiometry.**

In addition to the already existing procedure codes for bone mass measurements, the implementation of the BBA of 1997 created the following new procedure codes for services performed on or after July 1, 1998:

- **G0130 - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)**
- **G0131 - Computerized tomography bone mineral density study, one ore more sites; axial skeleton (e.g., hips, pelvis, spine)**
- **G0132 - Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist,, heel)**
- **76977 - Ultrasound bone density measurement and interpretation, peripheral site(s), any method**

To determine the 23-month period, start your count beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening pelvic examination in January 1998. Start your count beginning with February 1998. The beneficiary is eligible to receive another bone mass measurement test in January 2000 (the month after 23 full months have passed).

Deductible and co-insurance apply. Claims from physicians, other practitioners or suppliers where assignment was not taken are subject to the Medicare limiting charge.

Diabetes Self-Management Services

Section 4105 of the Balanced Budget Act of 1997 permits coverage of diabetes outpatient self-management training services when these services are performed by a certified provider who meets certain quality standards. This coverage is effective for services rendered on or after July 1, 1998.

A diabetes self-management and training service is a program that educates beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for self-management.

Outpatient self-management training services may be covered under Medicare only if the physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's conditions.

The BBA states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under Medicare, and meets certain quality standards. For purpose of this benefit, services provided by the following provider types can be covered, if all coverage criteria are met: physicians; physician assistants (PA); nurse midwives; clinical psychologists; and clinical social workers.

The following procedure codes have been developed for the purpose of billing for diabetes outpatient self-management training services:

- **G0108 - Diabetes outpatient self-management training services, individual session, per 60 minutes of training; and**
- **G0109 - Diabetes outpatient self-management training services, group session, per individual, per 60 minutes of training.**

Deductible and co-insurance applies. Claims from physicians, other practitioners or suppliers where assignment was not taken are subject to the Medicare limiting charge.

Vaccinations

Pneumococcal (PPV) and Influenza Vaccinations

Medicare coverage for pneumococcal vaccinations began on July 1, 1981 and for influenza vaccinations on May 1, 1993.

For the purpose of the influenza or PPV benefit, any individual or entity meeting state licensing requirements may qualify to have payment made for furnishing and administering the influenza vaccine or PPV to Medicare beneficiaries enrolled under Part B, as long as certain Medicare requirements are met.

Medicare does not require a physician to be present for the

influenza vaccination; however individual states may require physician involvement and/or physician order.

Unless PPV is administered under the supervision of a physician, Medicare requires either: (1) a prescription written specifically for the beneficiary who is receiving PPV; or (2) a previously written physician order, also known as a standing order. (A standing order is a prescription written in advance by a responsible, identifiable physician to cover certain common treatment situations). The standing order must specify that the individual or entity providing PPV must:

- determine the person's age, health and vaccination status;
- obtain a signed consent;
- administer an initial dose of PPV only to persons at high risk of pneumococcal disease, this group includes all individuals aged 65 or over; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, lymphoma);
- revaccinate only persons at highest risk of serious pneumococcal infection, this group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), congenital immunodeficiency, HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy and those likely to have a rapid decline in pneumococcal antibody levels, provided an least 5 years have passed since receipt of a previous dose of PPV; and
- provide a record of vaccination to the patient.

NOTE: For services rendered on or after July 1, 2000, the beneficiary can receive the PPV vaccine without a doctor's order or supervision. Therefore, a standard order is not required.

It is not necessary for a beneficiary to provide something in writing to show his/her PPC vaccination status, nor is it necessary for the provider to review the beneficiary's medical records. Individuals and entities providing PPV to Medicare beneficiaries may rely on a verbal account of vaccination status provided by a competent beneficiary.

High-risk individuals need PPV only once in a lifetime. Revaccination of persons 65 and older who are not at highest risk is not appropriate. If a beneficiary who is not at highest risk is revaccinated because of uncertainty about his/her PPV vaccination status, Medicare will cover the PPV revaccination.

Medicare generally pays for one influenza vaccine per season. Based on the various flu seasons, this could mean more than one vaccination in a year. Payment could be made for more than one vaccination per flu season if it is determined that it is medically reasonable and necessary.

The following procedure codes have been developed for the influenza vaccine:

- **90657 - Influenza virus vaccine, split virus, 6-35 mo.'s dosage, for intramuscular use or for jet injection;**
- **90658 - Influenza virus vaccine, split virus, 3 yr.'s and above dosage, for intramuscular use or for jet injection;**
- **90659 - Influenza virus vaccine, whole virus, for jet injection or intramuscular use; and**
- **G0008 - Administration of influenza virus vaccine**

If the sole purpose of the visit is to receive the influenza vaccine, the provider should utilize ICD-9-CM diagnosis code V04.8 (Influenza Vaccination).

The following procedure codes have been developed for PPV:

- **90732 - Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for either subcutaneous or intramuscular use; and**
- **G0009 - Administration of pneumococcal vaccine**

If the sole purpose of the visit is to receive the PPV, the provider should utilize ICD-9-CM diagnosis code V03.82 (Pneumococcal Vaccination).

For the influenza and PPV vaccines, both the administration and the cost of the vaccine is reimbursed. Medicare pays 100% of the approved amount or the submitted charge, whichever is lower for both the influenza and PPV vaccines and administration. Deductible and co-insurance does not apply.

Both influenza and the PPV immunizations can be filed to Medicare utilizing traditional billing methods. However, if you are giving "mass" immunizations to a large Medicare population, you may use a simplified roster billing. Your Medicare carrier can provide you with billing details.

Hepatitis B Vaccinations

Effective for services rendered on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting Hepatitis B.

The following procedure codes have been developed for hepatitis B vaccinations:

- **90744 - Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;**
- **90745 - Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use;**
- **90746 - Hepatitis B vaccine, adult dosage, for intramuscular use;**

- **90747 - Hepatitis B vaccine, dialysis or immunosupressed patient dosage, for intramuscular use;**
- **90748 - Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use; and**
- **G0010 - Administration of hepatitis B vaccine.**

If the sole purpose of the visit is to receive the hepatitis B vaccine, the provider should utilize ICD-9-CM diagnosis code V05.3 (Hepatitis B Vaccine).

For the hepatitis B vaccine, both the administration and the cost of the vaccine is reimbursed. Medicare pays 80% of the approved amount or the submitted charge, whichever is lower for both the vaccine and administration. Deductible and co-insurance does apply.

Screening Mammography Services:

Screening mammographies are regular, routine radiological examinations for early detection of breast cancer and include a physician's interpretation of the results. They are conducted for preventive services, when there are no clinical indications or symptoms. A physician's prescription or referral is not required for coverage of a screening mammogram.

Beginning January 1, 1991, Medicare began to provide coverage for screening mammography services based on diagnosis and limitation requirements. As of October 1, 1994, the Mammography Quality Standards Act (MQSA) requires that all mammography centers that bill Medicare get certification from the Food and Drug Administration (FDA). The FDA sends certification information to HCFA, who forwards it to the individual carriers. Carriers are urged to notify providers under their jurisdiction, at least once a year, regarding names of certified mammography centers. Refer to your local contractor for a list of covered centers in your area. The name and number of the mammography center is a required entry on a claim for screening mammography. It is entered in block 32 of the HCFA-1500 claim form or in the designated electronic formatted field.

The Balanced Budget Act of 1997 revised Medicare coverage requirements for screening mammographies. These changes became effective for services rendered on or after January 1, 1998. These changes are as follows:

- women between the ages of 35-39 are covered for one screening mammogram during that 5-year period;
- women age 40 and above are covered for one screening mammogram per 12-month period; and
- the usual Medicare Part B deductible is waived.

For women age 40 and older, determine the per 12-month time frame as follows: 12 months have elapsed since the last screening; begin counting with the month after the last exam. For example, if a woman had an exam on February 25, 1999, you would begin counting with the month of March, 1999. She would then be eligible for her next screening mammogram on or after February 25, 2000.

The following procedure code has been developed for screening mammographies:

- **76092 - Screening mammography, bilateral (two view film study of each breast)**

Medicare allows a radiologist to order additional mammography views when a screening mammography shows a potential problem. Where a radiologist's interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or payment purposes. This can be done without an additional order from the treating physician. In this case, a diagnostic x-ray procedure code should be billed instead of the screening mammography.

The diagnostic mammography codes are as follows:

76090 - Mammography; unilateral; and
76091 - Mammography; bilateral.

In the situations in which a screening mammogram was changed to a diagnostic mammogram, based on the interpretation of the radiologist, modifier code GH should be added in block 24f of the HCFA-1500 claim form or the designated electronic formatted field. The usage of this modifier is for statistical purposes in order to track the frequency of this type of situation.

Screening Pap Smear Services

Section 4102 of the Balanced Budget Act of 1997 provides more frequent coverage for women deemed to be at high risk or whose Pap smears have indicated the presence of vaginal cancer or other abnormalities in the past three years. This includes coverage for women who exhibit any of the following conditions:

- women who are either at high risk of developing cervical or vaginal cancer; or
- women who are of childbearing age who have had a Pap smear during any of the preceding three years indicating the presence of cervical or vaginal cancer.

Screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under state law to perform the examination) under the following conditions:

- the beneficiary has not had a screening Pap smear test during the preceding three years and is at low risk for developing cervical or vaginal cancer (use ICD-9-CM code V76.2, special screening for malignant neoplasm, cervix); or

- there is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding three years; or that she is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health).

High risk factors for cervical and vaginal cancer are:

- early onset of sexual activity (under 16 years of age) (use ICD-9-CM code V69.2, high risk sexual behavior as a secondary diagnosis to V15.89);
- multiple sexual partners (five or more in a lifetime);
- history of sexually transmitted disease (including HIV infection);
- fewer than three negative or any Pap smears within the previous seven years; and
- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

NOTE: Claims for screening Pap smears **must** indicate the beneficiary's low or high risk status by including the appropriate ICD-9-CM on the line item (either in block 24e of the HCFA-1500 claim form or the designated electronic formatted field). ICD-9-CM diagnosis code V76.2 indicates low risk and V15.89 indicates high risk.

The following procedure codes have been developed for screening pap smear services:

- **G0123 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision;**
- **G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician;**
- **G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician;**
- **G0143 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision;**
- **G0144 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision;**
- **G0145 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening using cell selection and review under physician supervision;**
- **G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision;**
- **G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening;**
- **P3000 - Screening Papanicolaou Smear, cervical or vaginal, up to three smears, by technician under physician supervision; and**
- **P3001 - Screening Papanicolaou Smear, cervical or vaginal, up to three smears, requiring interpretation by physician.**

For the screening Pap smear procedure, Medicare pays 100% of the approved amount or the submitted charge, whichever is lower. Deductible and co-insurance does not apply.

Screening Pelvic Examination

Section 4102 of the Balanced Budget Act of 1997 provides for coverage of screening pelvic examinations (including a clinical breast examination) for all female beneficiaries, effective January 1, 1998, subject to certain coverage, frequency and payment limitations.

A screening pelvic examination (including a clinical breast examination) should include at least seven of the following eleven elements:

- inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- pelvic examination (with or without specimen collection for smears and cultures) including:
    - external genitalia (e.g., general appearance, hair distribution, or lesions);
    - urethral maetus (e.g., size, location, lesions or prolapse);
    - urethra (e.g., masses, tenderness or scarring);
    - bladder (e.g., fullness, masses or tenderness);
    - vagina (e.g., general appearance, estrogen effect, discharge lesions, pelvic support, cystocele or rectocele);
    - cervix (e.g., general appearance, lesions or discharge);
    - uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support);
    - adnexa/parametria (e.g., masses, tenderness, organomegaly or nodularity);
    - anus and perineum.

Medicare Part B pays for a screening pelvic examination if it is performed by a doctor of medicine or osteopathy, or by a clinical nurse midwife, physician assistant, nurse practitioner, clinical nurse specialist who is authorized under state law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Payment may be made for a screening pelvic examination performed on an asymptomatic woman only if she has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare covered screening pelvic examination was performed (use ICD-9-CM diagnosis code V76.2, special screening for malignant neoplasm, cervix) except as follows:

Payment may be made for a screening pelvic examination performed more frequently than every 36 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer, or vaginal cancer). Use ICD-9-CM diagnosis code V15.89, other specified personal history presenting hazards to health.

The high risk factors for cervical and vaginal cancer are:

Cervical cancer high risk factors:

- early onset of sexual activity (under 16 years of age) (use ICD-9-CM code V69.2, high risk sexual behavior as a secondary diagnosis to V15.89);
- multiple sexual partners (five or more in a lifetime);
- history of sexually transmitted disease (including HIV infection); and
- fewer than three negative or any Pap smears within the previous seven years

Vaginal cancer high risk factor:

- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy

The following prodecure code has been developed for a screening pelvic examination:

- **G0101 - Cervical or vaginal cancer screening; pelvic and clinical breast examination.**

Medicare payment for a screening pelvic examination performed more frequently than once every 36 months can also be made if the examination is performed by a physician or other covered practitioner, for a woman of childbearing age, who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years.

Medicare payment is not made for a screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

To determine the 11 and 35 month periods, start your count beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening pelvic examination in January 1998. Start your count beginning with February 1998. The beneficiary is eligible to receive another pelvic exam in January 1999 (the month after 11 full months have passed), if the 12 month requirement is met.

Screening for Colorectal Cancer

Section 4104 of the Balanced Budget Act of 1997 provides for coverage of various colorectal screening examinations subject to coverage, frequency and payment limitations. Effective for services rendered on or after January 1, 1998, Medicare will cover colorectal cancer screening test/procedures for the early detection of colorectal cancer. Coverage of colorectal cancer screening includes the following tests/procedures:

- screening fecal-occult blood test;
- screening flexible sigmoidoscopy;
- screening colonoscopy, for high risk individuals; and
- screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy.

The following new HCPCS codes have been established for these services:

- **G0107 - Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations;**
- **G0104 - Colorectal cancer screening; flexible sigmoidoscopy;**
- **G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;**
- **G0106 - Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy;**
- **G0120 - Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy;**
- **G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (non-covered); and**
- **G0122 - Colorectal cancer screening; barium enema (non-covered).**

The following are the coverage criteria for these new screenings:

- Screening fecal-occult blood tests (**code G0107**) are covered at a frequency of once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). Screening fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for

using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

- Screening flexible sigmoidoscopies (**code G0104**) are covered at a frequency of once every 48 months for beneficiaries who have attained age 50 (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done). If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed and paid rather than code **G0104**. A doctor of medicine or osteopathy must perform this screening.

- Screening colonoscopies (**code G0105**) are covered at a frequency of once every 24 months for beneficiaries at high risk for colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered screening colonoscopy was done). High risk for colorectal cancer means an individual with one or more of the following:

  -a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyposis;

  -a family history of familial adenomatous polyposis;

  -a family history of hereditary nonpolyposis colorectal cancer;

  -a personal history of adenomatous polyps; or

  -a personal history of colorectal cancer; or

  -inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

  If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code **G0105**. A doctor of medicine or osteopathy must perform this screening.

- Screening barium enema examinations **G0106** and **G0120** are covered as an alternative to either a screening sigmoidoscopy (**code G0104**) or a screening colonoscopy (**code G0105**) examination. The same frequency parameters specified in the law for screening sigmoidoscopy and screening colonoscopy apply.

In the case of an individual age 50 or over who is not at high risk of colorectal cancer, payment may be made for a screening barium enema examination performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy, or for a screening colonoscopy, as appropriate, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

Listed below are some examples of diagnoses that meet the high risk criteria for colorectal cancer. This is not an inclusive list. There may be more instances of conditions that may be coded and could be at the medical directors' discretion.

ICD-9-CM Codes

Personal History:

V10.05 Personal history of malignant neoplasm of large intestine

V10.06 Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Chronic Digestive Disease Condition

555.0 Regional enteritis of small intestine

555.1 Regional enteritis of large intestine

555.2 Regional enteritis of small intestine with large intestine

555.9 Regional enteritis of unspecified site

556.0 Ulcerative (chronic) enterocolitis

556.1 Ulcerative (chronic) ileocolitis

556.2 Ulcerative (chronic) proctitis

556.3 Ulcerative (chronic) proctosigmoiditis

556.8 Other ulcerative colitis

556.9 Ulcerative colitis, unspecified (non-specific PDX on the MCE)

Inflammatory Bowel

558.2 Toxic gastroenteritis and colitis

558.9 Other and unspecified non-infectious gastroenteritis and colitis

Code **G0121 (colorectal cancer screening; colonoscopy on an individual not meeting criteria for high risk**) should be used when this procedure is performed on a beneficiary who does *NOT* meet the criteria for high risk. This service is denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

Code G0122 (colorectal cancer screening; barium enema) should be used when a screening barium enema is performed *NOT* as an alternative to either a screening colonoscopy (code **G0105**) or a screening flexible sigmoidoscopy (code **G0104**). This service is denied as non-covered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

Reporting of these non-covered codes will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

To determine the 11, 23, and 47-month periods, start your count beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a fecal-occult blood test in January 1998. Start your count beginning with February 1998. The beneficiary is eligible to receive another blood test in January 1999 (the month after 11 full months have passed).

For the colorectal screening procedures, Medicare pays 80% of the approved amount or the submitted charge, whichever is lower. Deductible and co-insurance does apply.

Prostate Cancer Screening Tests and Procedures

Section 4103 of the Balanced Budget Act of 1997 provides for coverage of certain prostate cancer screening tests and procedures subject to certain coverage, frequency and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare will cover prostate cancer screening tests and procedures for the early detection of prostate cancer. Coverage of prostate cancer screening includes the following tests/procedures:

- screening digital rectal examination - this is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate; and
- screening prostate specific antigen (PSA) blood test - this test detects the marker for adenocarcinoma of the prostate.

The following new HCPCS codes have been established for these services:

- **G0102 - Prostate cancer screening; digital rectal examination; and**
- **G0103 - Prostate cancer screening; PSA test**.

The following are the coverage criteria for these new screenings:

- The digital rectal examination (**code G0102**) is covered if all of the following criteria are met:
  - it is performed on a male Medicare beneficiary aged 50 or older;
  - it is performed by one of the following types of providers: doctor of medicine or osteopathy; qualified physician assistant; qualified nurse practitioner; qualified clinical nurse specialist or a qualified certified nurse midwife; and
  - it is performed at a frequency of no more than once every 12 months.

- The PSA test (code **G0103**) is covered if all of the following criteria are met:
  - it is performed on a male Medicare beneficiary aged 50 or older;
  - it is ordered by the beneficiary's attending: physician (doctor of medicine or osteopathy); qualified physician assistant; qualified nurse practitioner; qualified clinical nurse specialist or a qualified certified nurse midwife; and
  - it is performed at a frequency of no more than once every 12 months.

For the digital rectal examination, Medicare pays 80% of the approved amount or the submitted charge, whichever is lower. Deductible and co-insurance does apply. For the PSA test; however, Medicare pays 100% of the approved amount or the submitted charge, whichever is lower. Deductible and co-insurance does not apply.

Facility Fee Pricing Schedule

Services that are primarily performed in office settings are subject to a payment limit if they are performed in:

- an inpatient or outpatient hospital setting;
- a hospital emergency room;
- a skilled nursing facility;
- a comprehensive inpatient or outpatient rehabilitation facility;
- an inpatient psychiatric facility; or
- an Ambulatory Surgical Center.

The Medicare reimbursement is reduced because the physician's overhead and other related expenses are not as great as if they were performed in other settings, such as his/her office. Providers are not allowed to bill the beneficiary for the reduced allowance based on where the services were performed.

Note: For all of the above calculations, the allowed amount will be the lower of the actual charge or the reduced fee schedule amount.

A national list of procedures subject to this fee schedule pricing has been established. Carriers are required to publish these facility fee pricing schedules allowances.

Surgery Policies

The following section addresses some Medicare payment policies applicable to the surgical patient.

Global Surgery Policy

Global surgery includes all necessary services normally furnished by a surgeon before, during and after the surgical procedure. Payment for the surgical procedure includes the preoperative, intraoperative and postoperative services routinely performed by the surgeon.

The global surgery policy only applies to surgical procedures for which there are postoperative periods of 0, 10 or 90 days. Services are divided into categories of major or minor surgery.

Procedures with either 0 or 10 follow-up days are considered either minor surgical procedures or endoscopies.

Procedures with 90 follow-up days are considered major surgery.

The approved amount for a procedure subject to the global surgery policy includes payment for the following services furnished by the surgeon which are related to the surgery:

- pre-operative visits rendered after the decision is made to operate beginning one day prior to the surgery for major surgical procedures and the day of surgery for minor surgical procedures;
- intra-operative services that are normally a usual and necessary part of the surgical procedure;
- all additional medical or surgical services required of the surgeon during the post-operative period because of complications which do not require additional trips to the operating room;
- post-surgical pain management by the surgeon;
- certain supplies (which are a normal part of the surgical procedure);
- miscellaneous services such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes/removal of tracheostomy tubes; and
- post-operative visits during the post operative period of the surgery that are related to the recovery of the surgery.

Note: The physician is precluded from billing these services separately and billing the patient separately.

Services not included in the global surgery package and which may be reimbursed separately include:

- the initial evaluation or consultation by the surgeon to determine the need for the surgery;
- treatment for postoperative complications requiring a return trip to the operating room or reoperations;
- visits during the post-operative period which are unrelated to the surgical procedure unless the visits occur due to complications from the surgery;
- treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery;
- services of other physicians except when the surgeon and the other physician(s) agree on the transfer of care;
- clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications;
- diagnostic tests and radiological procedures;
- the performance of a more extensive procedure if a less extensive procedure fails;
- surgical trays (HCPCS code A4550) furnished in the physician's office for certain designated procedures. Local carriers generally publish the surgical procedures applicable to this provision;
- immunosuppressive therapy for organ transplants; and
- critical care services which are unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Global Surgery Modifiers

Decision For Surgery - Modifier 57

Evaluation and management furnished by the surgeon on the day before, or on the day of, **major** surgery that results in the initial decision to perform the surgery may be covered separately from the surgery. In these instances, modifier **57** should be reported on the evaluation and management service.

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - Modifier 25

Evaluation and management services furnished on the same day as a **minor** surgical procedure may be covered separately only if the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure. In these instances, procedure code modifier **25** should be reported with the evaluation and management service.

Note: When utilizing the above modifier, it is necessary to document (in the medical record) the reason why the visit was unrelated to a surgical procedure.

Unrelated Evaluation and Management Service by the Same Physician During the Postoperative Period - Modifier 24

Unrelated evaluation and management services furnished by the same physician in the post-operative period of a **major** surgical procedure may be covered. In these instances, procedure code modifier **24** should be reported with the evaluation and management service.

Note: When utilizing the above modifier, it is necessary to document (in the medical record) the reason why the visit was unrelated to a surgical procedure.

Return to the Operating Room for a Related Procedure During the Post Operative Period - Modifier 78

When treatment for complications requires a **return** trip to the operating room, separate payment may be made for the procedure (whether it is the same or different procedure). In these cases, modifier **78** should be reported with the procedure.

Unrelated Procedure or Service by the Same Physician During the Postoperative Period - Modifier 79

Separate payment may be made for a surgical procedure which is furnished during the post operative period when it is **unrelated** to the other procedure. In these cases, modifier **79** should be used on the procedure. A new post-operative period begins when the unrelated procedure is billed.

Note: When utilizing the above modifier, it is necessary to document (in the medical record) the reason why the visit was unrelated to a surgical procedure.

Staged or Related Procedure or Service by the Same Physician During the Postoperative Period - Modifier 58

This modifier was created to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not to be used to report the treatment of a problem that requires a return to the operating room.

The physician may need to add the **58** modifier to the surgical procedure that was performed during the postoperative period was:

- planned prospectively or at the time of the original procedure;
- more extensive than the original procedure; or
- for therapy following a diagnostic surgical procedure.

A new post-operative period begins when the next procedure in the series is billed.

Multiple Surgery

When covered, multiple surgical procedures are billed on the same day by the same physician, the allowance is based on 100% of the fee schedule amount for the procedure with the highest Medicare fee allowance and 50% of the fee schedule amount for the 2nd, 3rd, 4th, and 5th procedures. When more than five procedures (which are subject to multiple surgery rules) are performed on the same day by the same provider, medical documentation (i.e., the operative report) must be submitted with the claim.

Bilateral Procedures

A Bilateral procedure is defined as a procedure performed on both sides of the body within the same session. The payment rules for bilateral procedures are as follows:

Procedures Which Are Bilateral in Nature:

There are certain procedures that the fee schedule has been calculated to take into account it begin performed as a bilateral procedure. The fee schedule was established as a bilateral service because:

- the code description specifically states that the procedure

is bilateral;
- the code description states that the procedure may be performed either bilaterally or unilaterally; or
- the procedure is typically performed as a bilateral procedure.

When filing a claim for these procedures, regardless of whether the service was performed unilaterally or bilaterally, bill the procedure code on one detail line with no bilateral surgery modifier.

Procedures Allowed at 150% of the Fee Schedule:

For other procedures performed bilaterally, payment will be made at the lower of the billed amount or 150% of the fee schedule allowance. Claims for these procedures should be billed on a single claim detail line with the **50** modifier **(Bilateral Procedure)**. This modifier indicates the procedure was performed on both sides of the body.

Procedures Allowed at 100% of the Fee Schedule (Each Procedure):

There are certain procedures which are allowed at 100% of the fee schedule for each side of the body when performed bilaterally.

To report these services, either of the following methods may be used:

- Bill the procedure on a single detail line with a **50** modifier **(Bilateral Procedure)** and double your billed amount. The allowance will be made at 200% of the fee schedule; or

- Bill the procedure on two claim detail lines with modifier LT (Left Side) on one line and modifier RT (Right Side) on the other. The allowance will be made at 100% of the fee schedule for each procedure.

Note: Do not bill these services with both the 50 and the LT or RT modifiers.

All carriers publish the lists of CPT codes applicable to the above bilateral rules. If you are performing a bilateral procedure and you would like to know more about the reimbursement and billing procedure, contact your local carrier.

Assistant-at-Surgery

An assistant-at-surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. For Medicare purposes, not all surgical procedures are deemed to require an assistant-at-surgery, but for those which are, the Medicare Part B allowable amount may be no more than 16% of the fee schedule allowance for the surgical procedure. Each carrier should publish a list of services which allow a surgical assistant. Assistant-at-surgery services require the use of modifier **80 (Assistant Surgeon)**.

Note: Assistant-at-surgery for multiple procedures is allowed at 8% of the fee schedule allowance for the 2nd through 5th additional covered procedures and on a "by report" basis for any additional surgical services (greater than five) provided to the patient on the same day.

Assistant-at-surgery charges are not covered by Medicare for procedures where it is found that assistants-at-surgery have been used in fewer than 5% of the cases, based on a national average. The physician may not charge the patient for these services.

Co-Surgeons, Two Surgeons and Surgical Teams

Co-Surgeons:

There are two categories of surgical procedures for which co-surgery may be covered. The **first** category is defined for certain surgical procedures when:

- the specialties of the physicians are different;

- the same surgical procedure (same CPT code) is performed, and

- the procedure is considered medically necessary.

Claims for these procedures must be filed with the **operative report**. Each surgeon should bill the CPT code for the surgery performed and use modifier **62 (Two Surgeons)**. Reimbursement for each co-surgeon will be based on 62.5% of the fee schedule allowance of the surgical procedure.

The **second** co-surgery category is defined for certain surgical procedures when:

- the specialties of the physicians are different; and

- the same surgical procedure (same CPT code) is performed.

For these procedures, **no operative report** is required by the carrier.

All carriers publish the lists of CPT codes applicable to these co-surgery requirements. Since the services of a co-surgeon could be considered not medically necessary, an acceptable advance notice of Medicare's possible denial must be provided to the patient when the surgeons do not want to accept financial responsibility for the service.

Co-surgery does not exist when two surgeons perform separate distinct surgical procedures on the same patient during the same operative session. In these cases, each

surgeon should bill separately for the procedure performed. The allowance for each procedure will be based made at 100% of the fee schedule, and each procedure will maintain its own follow-up period because the procedures are not related. If any or both of the surgeons perform more than one surgery in the same surgical session, reimbursement will be made according to multiple surgery guidelines.

Surgical Teams:

Surgical teams composed of several physicians/personnel (e.g., trauma teams) equipped to perform highly complex procedures. To file a claim for team surgery, each physician should bill the procedure appropriate for his service, add modifier **66 (Surgical Team)**. Submit an operative report with the claim. Payment for team surgery is determined on a per claim basis.

Dermatological Surgery

For certain dermatological services, there are separate CPT codes which indicate that multiple surgical procedures have been performed (e.g., Removal of skin tags, up to and including 15 lesions). For these codes, the multiple surgical procedure reimbursement rules do not apply. Rather, the RVU for each of these procedures codes are set to reflect the reduction of the pre/post-operative work and the practice expense.

For other certain dermatological procedure codes which do not specify that multiple procedures have been performed, reimbursement is based on multiple surgery guidelines.

Certain surgical procedures performed incidental to other surgical procedures by the surgeon or his assistant are covered. However, the reimbursement is included in the allowance for the major procedure. For example, a dilation and curettage is generally a covered service when billed alone, but the reimbursement would be included in the allowance of a hysterectomy when performed on the same day by the same provider or PA group. Physicians may not bill patients for procedures that are included in the allowance of the major procedure.

How To Report Split Care For Surgery

Physicians Who Furnish the Global Package

In cases where one physician performs the surgical procedure and furnishes all of the usual pre-and postoperative services, only the surgical procedure should be billed. Visits or other services that are included in the global package should not be billed separately.

Physicians Who Furnish Part of the Global Package

In cases where physicians agree on the transfer of care during the global period, each physician will report his/her services as follows:

- modifier code **54 (Surgical Care Only)** should be reported for the surgery only;
- modifier code **55 (Postoperative Management Only)** should be reported for the postoperative care only.

Both the claim for the surgical care only and the claim for the postoperative care only should indicate the same date of surgery and the same surgical procedure code with the appropriate modifiers. The date(s) on which care was relinquished and assumed must be indicated on the claim (block 19 on the HCFA 1500 or the designated electronic formatted field).

Services Not Reimbursable Under The Medicare Program

There are four classifications for services which are not reimbursable from the Medicare program:

- services which the Medicare program never covers (services which are considered non-covered);
- services considered not medically necessary;
- services denied as bundled/included in the basic allowance of another service; and
- claims denied as unprocessable.

The following lists provide examples within each classification:

I. Non-Covered Services

The following services are never paid by Medicare. There is no Medicare fee schedule amount associated with the non–covered procedure. Therefore, you may charge the patient what you feel is appropriate without having to get a waiver signed.

These services include, but are not limited to:

- routine (annual or otherwise) physicals;
- screening tests with no symptoms or documented conditions;**
- personal comfort or convenience items;
- care provided in facilities located outside of the United States, Puerto Rico, the U.S. Virgin Islands, Guam,

American Samoa, and the Northern Mariana Islands;

- custodial care;
- oral medications,
- self-administered drugs;
- routine foot care;
- prophylactic dental care;
- exams for purposes of prescribing a hearing aid or eyeglasses; and/or
- cosmetic surgery.

****Note**: Medicare allows specific routine screening tests such as pap smears, routine screening mammogram services, colorectal cancer screening services, etc. Please refer to the "Preventive Medicine" section of this chapter for details.

Services "related to" non-covered services, including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, also remain not covered services under Medicare. For example, a routine physical exam is not covered under Medicare. All lab tests and other services related to the routine physical exam are also not covered under Medicare.

Services "not related to" non-covered services are covered under Medicare.

II. Not Medically Necessary Services

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. When such services are denied, a waiver must be signed by the patient prior to rendering the service and collecting any monies for the service.

Not medically necessary services include but are not limited to:

- services provided in a hospital or skilled nursing facility (SNF) that based on the condition of the patient could have been provided elsewhere (such as the home or a nursing home);
- services in a hospital or SNF which exceed the Medicare limitation regarding length of stay;
- evaluation and management (E/M) services provided in excess of what is considered medically reasonable and necessary;
- therapy or diagnostic procedures provided in excess of the Medicare carrier utilization limits or screens;
- services provided which are only paid by Medicare when the patient has a specific covered diagnosis.

III. Bundled/Basic Allowance Services

There are services which are considered included in the basic allowance of another procedure and cannot be charged to the patient. These services are also referred to as "bundled/basic allowance services".

These services include but are not limited to:

- fragmented service, included in the basic allowance of the initial service;
- prolonged care (indirect);
- physician standby services;
- case management services (such as telephone calls to/from patients);
- supplies included in the basic allowance of a procedure.

In 1994, HCFA awarded a contract to AdminaStar Federal, to define "correct coding practices." This effort, referred to as the Correct Coding Initiative (CCI) was used as the basis for national Medicare policy for payment of claims.

The CCI policy is based on two types of inappropriate coding combinations:

Comprehensive and component code combinations;Mutually exclusive coding combinations that represent services or procedures that would not or could not be performed at the same time, based on the CPT/HCPCS code description or standard medical practice. These coding combinations are published by the National Technical Information Services (NTIS) and can be purchased by contacting the organization at:

To request a single issue of the National Correct Coding Policy Manual, call (703) 605-6500.

For a subscription to the National Correct Coding Policy Manual, call (703) 605-6060, or (800) 363-2068.

To receive information from NTIS by mail, call (800) 553-6847.

If you may request the CD ROM version Order #SUB-5407 ($80.00 plus handling), the ASCII version (raw data) Order #SUB-5408 ($140.00 plus handling), a paper copy subscription ($260.00), or a quarterly issue Order #SUB-9576 ($65.00 plus handling.)

Effective October 1, 1998, HCFA implemented new commercial edits to detect inappropriate billing

combinations (i.e., procedure to procedure code combinations), including those considered mutually exclusive and those considered incidental procedures.

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same dated of service. An incidental procedure is performed at the same time as a more complex primary procedure. The incidental procedure requires little additional physician work and/or clinically integral to the performance of the primary procedure.

Medicare considers all the services necessary to accomplish a given procedure to be included in the description of that procedure by CPT (copyright by the American Medical Association).

These additional edits are not part of the Correct Coding Initiative (CCI). These edits will not be available to the public in a mass publication like CCI because they are proprietary. The new commercial edits will not be published by the National Technical Information Service (NTIS). However, these edits have been reviewed for consistency with Medicare policy and approved by HCFA for Medicare implementation.

IV. Unprocessable Claims

Returning a claim as unprocessable does not mean Medicare will physically return every claim you submit with incomplete or invalid information. The term "return as unprocessable" is used to refer to the many processes used by Medicare today for notifying the physician that his/her claim cannot be processed, and that it must be corrected and resubmitted. Until the errors are corrected as noted on the claim, the claim cannot be paid and the physician cannot charge the beneficiary for the service.

Some of the various reasons for returning claims as unprocessable include:

- incomplete or invalid information is detected at the front-end of our claims processing system. Depending on how the claim is filed to Medicare, the claim is returned to the physician, either electronically or in a hard copy claim form, and may include a checklist form explaining the errors and how to correct them.

- incomplete or invalid information is detected at the front-end of the claims processing system (before the claim is finalized) and additional information is requested from the physician. If corrections are submitted within a 45 day period, the claim is finalized. Otherwise, the suspended portion is denied and "returned as unprocessable" as indicated in the remittance notice.

NOTES

CHAPTER 6
E/M DOCUMENTATION

This chapter contains the 1997 Documentation Guidelines (DGs) for Evaluation and Management (E & M) services. These guidelines are effective October 1, 1997. However, providers can document E&M services in accordance with the 1995 guidelines utilize the 1997 revised guidelines. The changes and additions include the following:

- the content of general multi-system examinations have been defined with greater clinical specificity,
- documentation requirements for general multi-system examinations have been changed,
- content and documentation requirements have been defined for examinations pertaining to ten organ systems,
- several editorial changes have been made in the definitions of the four types of exams, and
- the definition of an extended history of present illness has been expanded to include chronic or inactive conditions.

These Documentation Guidelines (**DG**), were developed jointly by HCFA and the AMA. These are the criteria used to review medical records for E/M services and provide documentation required to support a given level of service.

Reviewers should request copies of all applicable material in the medical record which could support the billed level of service. In addition to the progress note, the request should include any other appropriate documents such as physician order sheets for tests or, patient completed history forms. Reviewers should evaluate all of the information received from the provider and "give credit" for all submitted documentation, regardless of how the record is organized.

Foreword

These guidelines have been developed jointly by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA). HFCA's goal is to provide physicians and claims reviewers with advice about preparing or reviewing documentation for E/M services. In developing and testing the validity of these guidelines, special emphasis was placed on assuring that they:

- are consistent with the clinical descriptors and definitions contained in CPT,
- would be widely accepted by clinicians and minimize any changes in record-keeping practices, and
- would be interpreted and applied uniformly by users across the country.

Documentation Guidelines For Evaluation And Management (E/M) Services

I. Introduction

What Is Documentation And Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time;
- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What Do Payers Want And Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. General Principles Of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services:

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:

- reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
- assessment, clinical impression or diagnosis;
- plan for care; and
- date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.

III. Documentation Of E/M Services

This chapter provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components - History, Examination and Medical Decision Making - appear tn the services description for office and other outpatient, hospital observation, hospital inpatient, consultations, emergency department, nursing facility, domiciliary care, and home services.

Documentation guidelines are identified by the symbol DG.

The descriptors for the levels of E/M services recognize **seven components** which are used in defining the levels of E/M services.

These components are:

- **History;**
- **Examination;**
- **Medical Decision Making;**
- **Counseling;**
- **Coordination of Care;**
- **Nature of Presenting Problem; and**
- **Time.**

The first three components i.e., history, examination and medical decision making) are the key components in selecting the level of E/M service. Where visits consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

IV. Documentation of an Encounter Dominated by Counseling or Coordination of Care (Time):

In the case where counseling and/or coordination of care dominates **(more than 50%)** of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

●***DG:*** *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

The following groupings of Evaluation and Management Services are subject to Documentation Guidelines:

Evaluation and Management Services
Office or Outpatient
Hospital Observation
Hospital Inpatient - Initial
Consultations
Emergency Room Services
Nursing Facility Care
Domiciliary Care
Home Care

Initial Patient Office or Other Outpatient Visit
3 of 3 Elements Must be Met or Exceeded to Select That Level of E/M Code

Level	History	Examination	Decision Making
I	Problem focused history	Problem focused examination	**Straightforward**
II	Expanded problem focused history	Expanded problem focused examination	**Straightforward**
III	Detailed history	Detailed examination	**Low complexity**
IV	Comprehensive history	Comprehensive examination	**Moderate complexity**
V	Comprehensive history	Comprehensive examination	**High complexity**

Established Patient Office or Other Outpatient Visit
2 of 3 Elements Must be Met or Exceeded to Select That Level of E/M Code

Level	History	Examination	Decision Making
I	N/A	N/A	**N/A**
II	Problem focused history	Problem focused examination	**Straightforward**
III	Expanded problem focused history	Expanded problem focused examination	**Low complexity**
IV	Detailed history	Detailed examination	**Moderate complexity**
V	Comprehensive history	Comprehensive examination	**High complexity**

A. Documentation of History

The levels of E/M services are based on **four types of history** (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- chief complaint (CC);
- history of present illness (HPI);
- review of systems (ROS); and
- past, family and/or social history (PFSH).

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgement and the nature of the presenting problem(s).

●***DG:*** *The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

●***DG:*** *A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

- *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
- *noting the date and location of the earlier ROS and/or PFSH.*

●***DG:*** *The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

●***DG:*** *If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are as follows:

Chief Complaint (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

●***DG:*** *The medical record should clearly reflect the chief complaint.*

History of Present Illness (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location (e.g., where the problem is located);
- quality (e.g., sharp, dull, stabbing pain);
- severity (e.g., measured by a scale of 1 -10);
- duration (e.g., how long has this problem existed);
- timing (e.g., how long does it last.....l);
- context (e.g., it hurts when I.....);
- modifying factors (e.g., it feel better when I...); and
- associated signs and symptoms (e.g., swelling, redness).

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A ***brief*** HPI consists of **one to three** elements of the HPI.

●***DG:*** *The medical record should describe one to three elements of the present illness (HPI).*

An ***extended*** HPI consists of **at least four** elements of the HPI or the status of at least three chronic or inactive conditions.

●***DG:*** ***The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.***

Review Of Systems (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

A ***problem pertinent*** ROS inquires about the system **directly related** to the problem(s) identified in the HPI.

●***DG:*** *The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An ***extended*** ROS inquires about the system **directly related** to the problem(s) identified in the HPI and a **limited number of additional systems.**

●***DG:*** *The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A ***complete*** ROS inquires about the system(s) **directly related** to the problem(s) identified in the HPI ***plus*** **all additional body systems.**

●***DG:*** *At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible.* ***In the absence of such a notation, at least ten systems must be individually documented.***

Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

- ***past history***— (the patient's past experiences with illnesses, operations, injuries and treatments);

- ***family history—*** (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and

- ***social history—*** (an age appropriate review of past and current activities).

For certain E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A ***pertinent*** PFSH is a review of the history area(s) **directly related** to the problem(s) identified in the HPI.

●**DG:** *At least one specific item from* ***any*** *of the three history areas must be documented for a pertinent PFSH.*

A ***complete*** PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of **all three** history areas is required for services that by their nature include a **comprehensive** assessment or reassessment of the patient. A review of **two of the three** history areas is sufficient for **other services.**

CPT Procedure Codes For Initial Patients, Applicable To PFSH:

●***DG:*** *At least one specific item from **each** of the three history areas must be documented for a **complete PFSH** for the following categories of E/M services:*

Evaluation and Management Groupings
Office or Outpatient - Initial Patient
Hospital Observation
Hospital Inpatient - Initial Patient
Consultations
Comprehensive Nursing Facility Assessments
Domiciliary Care - Initial Patient
Home Care - Initial Patient

CPT Procedure Codes For Established Patients, Applicable To PFSH:

●***DG:*** *At least one specific item from **two** of the three history areas must be documented for a complete PFSH for the following categories of E/M services:*

Evaluation and Management Groupings
Office or Outpatient - Established Patient
Emergency Room Services
Domiciliary Care - Established Patient
Home Care - Established Patient

The following HISTORY table includes each of the three categories of history. Select each level and place a check next to the applicable type of HPI, ROS and PFSH. The row that has three checks will correspond to the level of history you have performed and documented for the history portion of your patient encounter.

For example:

A ***BRIEF*** HPI, an ***EXTENDED*** ROS and a ***COMPLETE*** PFSH = **Expanded Problem Focused History.**

Although the ROS and PFSH were higher, you must select the Expanded Problem Focused History because the HPI was Brief. Remember, the history category requires **all three** categories to meet or exceed a level in order to select that level of history.

History Table - All 3 Elements Must be Met to Select a Level of History

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PFSH)	Type of History
1. Brief* - 1 - 3 elements (below) must be documented	1. N/A	1. N/A	**Problem Focused**
2. Brief *- 1 - 3 elements (below) must be documented	2. Problem Pertinent - System directly related to problem identified in HPI.	2. N/A	**Expanded Problem Focused**
3. Extended* - 4 or more elements (below) must be documented	3. Extended - System directly related to problem identified in HPI and a limited number (2 to 9) of additional systems.	3. Pertinent - At least one specific item from any of the 3 history areas must be documented.	**Detailed**
4. Extended* - 4 or more elements (below) must be documented *Note: Always use the lower of the type of HPI chosen i.e., the 2nd Brief or the 2nd Extended.	4. Complete - System directly related to problem identified in HPI plus at least 10 additional systems must be reviewed.	4. Complete - 2 or 3* specific items from any of the 3 history areas must be documented. **Note: If initial encounter, all 3 (PFSH) must be documented.*	**Comprehensive**
ELEMENTS Location; Quality; Severity; Duration; Timing; Context; Modifying Factors; Associated Signs & Symptoms	**ROS** Constitutional Symptom; Eyes; Ears, Nose, Mouth & Throat; Cardiovascular; Respiratory; Gastrointestinal; Genitourinary; Musculoskeletal; Integumentary (skin and/or breast); Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic, Allergic/Immunologic	**PFSH AREAS** Past History; Family History; Social History	

B. Documentation of Examination

The levels of E/M services are based on **four types of examination**:

- ***Problem Focused*** — a limited examination of the affected body area or organ system.

- ***Expanded Problem Focused*** — a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).

- ***Detailed*** — an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).

- ***Comprehensive*** — a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular;
- Ears, Nose, Mouth and Throat;
- Eyes;
- Genitourinary (Female);
- Genitourinary (Male);
- Hematologic/Lymphatic/Immunologic;
- Musculoskeletal;
- Neurological;
- Psychiatric;
- Respiratory; and
- Skin.

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgement, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in the following tables. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (●) in the right column.

Parenthetical examples, "(e.g., ...)", have been used for clarification and to provide guidance regarding documentation.

Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven...*") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen"*) require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- ●***DG:*** *Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- ●***DG:*** *Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.*
- ●***DG:*** *A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

General Multi-System Examinations

General multi-system examinations are described in detail. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- ***Problem Focused Examination*** — should include performance and documentation of **one to five elements** identified by a bullet (●) in one or more organ system(s) or body area(s).

- ***Expanded Problem Focused Examination*****—**should include performance and documentation of **at least six elements** identified by a bullet (●) in one or more organ system(s) or body area(s).

- ***Detailed Examination*****—**should include **at least six organ systems or body areas**. For each system/area selected, performance and documentation of **at least two elements** identified by a bullet (●) is expected. Alternatively, a detailed examination may include performance and documentation of **at least twelve elements** identified by a bullet (●) in two or more organ systems or body areas.

- ***Comprehensive Examination*** **—** should include **at least nine organ systems or body areas**. For each system/area selected, **all elements** of the examination identified by a bullet (●) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of **at least two elements** identified by a bullet is expected.

Single Organ System Examinations

The single organ system examinations recognized by CPT are described in this section. Variations among these examinations in the organ systems and body areas identified

in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- ***Problem Focused Examination***—should include performance and documentation of **one to five elements** identified by a bullet (●), whether in a box with a bold or normal border.

- ***Expanded Problem Focused Examination***—should include performance and documentation of **at least six elements** identified by a bullet (●), whether in a box with a bold or normal border.

- ***Detailed Examination***—examinations other than the eye and psychiatric examinations should include performance and documentation of **at least twelve elements** identified by a bullet (●), whether in box with a bold or normal border.

Eye and **psychiatric** examinations should include the performance and documentation of at least **nine elements** identified by a bullet (●), whether in a box with a bold or normal border.

- ***Comprehensive Examination***—should include performance of **all elements** identified by a bullet (●), whether in a bold or normal box. Documentation of **every element in a box with a bold border and at least one element in a box with a normal border** is expected.

General Multi-System Examination:

System/Body Area	Elements of Examination
Constitutional	● Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) ● General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	● Inspection of conjunctivae and lids ● Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) ● Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	● External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) ● Otoscopic examination of external auditory canals and tympanic membranes ● Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) ● Inspection of nasal mucosa, septum and turbinates ● Inspection of lips, teeth and gums ● Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	● Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) ● Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	● Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) ● Percussion of chest (e.g., dullness, flatness, hyperresonance) ● Palpation of chest (e.g., tactile fremitus) ● Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	● Palpation of heart (e.g., location, size, thrills) ● Auscultation of heart with notation of abnormal sounds and murmurs **Examination of:** ● carotid arteries (e.g., pulse amplitude, bruits) ● abdominal aorta (e.g., size, bruits) ● femoral arteries (e.g., pulse amplitude, bruits) ● pedal pulses (e.g., pulse amplitude) ● extremities for edema and/or varicosities
Chest (Breasts)	● Inspection of breasts (e.g., symmetry, nipple discharge) ● Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

System/Body Area	Elements of Examination
Gastrointestinal (Abdomen)	● Examination of abdomen with notation of presence of masses or tenderness ● Examination of liver and spleen ● Examination for presence or absence of hernia ● Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses ● Obtain stool sample for occult blood test when indicated
Genitourinary Genitourinary (continued)	**MALE:** ● Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass) ● Examination of the penis ● Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including ● Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) ● Examination of urethra (e.g., masses, tenderness, scarring) ● Examination of bladder (e.g., fullness, masses, tenderness) ● Cervix (e.g., general appearance, lesions, discharge) ● Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support) ● Adnexa/parametria (e.g., masses, tenderness, organ omegaly, nodularity)
Lymphatic	Palpation of lymph nodes in **two or more** areas: ● Neck ● Axillae ● Groin ● Other
Musculoskeletal	● Examination of gait and station ● Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: ● Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions ● Assessment of range of motion with notation of any pain, crepitation or contracture ● Assessment of stability with notation of any dislocation (luxation), subluxation or laxity ● Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	● Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) ● Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)
Neurologic	● Test cranial nerves with notation of any deficits ● Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski) ● Examination of sensation (e.g., by touch, pin, vibration, proprioception)
Psychiatric	● Description of patient's judgment and insight Brief assessment of mental status including: ● orientation to time, place and person ● recent and remote memory ● mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for General Multi-System Examination:

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements by a bullet **from each of the nine areas/systems.**

Single Organ System Examinations:
Cardiovascular Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids (e.g., xanthelasma)
Ears, Nose, Mouth and Throat	• Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (e.g., distension; a, v or cannon a waves) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (e.g., location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds and murmurs • Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation) Examination of: • Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (e.g., size, bruits) • Femoral arteries (e.g., pulse amplitude, bruits) • Pedal pulses (e.g., pulse amplitude) • Extremities for peripheral edema and/or varicosities
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person, • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Cardiovascular Examination:

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with a normal border.

Ear, Nose and Throat Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (e.g., use of sign language or other communication aids) and quality of voice
Head and Face	• Inspection of head and face (e.g., overall appearance, scars, lesions and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
Eyes	• Test ocular motility including primary gaze alignment
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (e.g., whispered voice, finger rub) • External inspection of ears and nose (e.g., overall appearance, scars, lesions and masses) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (e.g., pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Neurological/ Psychiatric	• Test cranial nerves with notation of any deficits Brief assessment of mental status including: • Orientation to time, place and person, • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Ear, Nose and Throat Examination:

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with a normal border.

Eye Examination

System/Body Area	Elements of Examination
Eyes	• Test visual acuity (Does not include determination of refractive error) • Gross visual field testing by confrontation • Test ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctivae • Examination of ocular adnexae including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria) and morphology • Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film • Slit lamp examination of the anterior chambers including depth, cells, and flare • Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) Ophthalmoscopic examination through dilated pupils (unless contraindicated) of • Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (e.g., exudates and hemorrhages)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Eye Examination:

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with a normal border.

Genitourinary Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary (female)]
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood test when indicated
Genitourinary	**MALE:** • Inspection of anus and perineum **Examination (with or without specimen collection for smears and cultures) of genitalia including:** • Scrotum (e.g., lesions, cysts, rashes) • Epididymides (e.g., size, symmetry, masses) • Testes (e.g., size, symmetry, masses) • Urethral meatus (e.g., size, location, lesions, discharge) • Penis (e.g., lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) **Digital rectal examination including:** • Prostate gland (e.g., size, symmetry, nodularity, tenderness) • Seminal vesicles (e.g., symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, rectal masses
Genitourinary (Cont'd)	**FEMALE:** Includes **at least seven of the following eleven** elements identified by bullets: • Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses Pelvic examination (with or without specimen collection for smears and cultures) including: • External genitalia (e.g., general appearance, hair distribution, lesions) • Urethral meatus (e.g., size, location, lesions, prolapse) • Urethra (e.g., masses, tenderness, scarring) • Bladder (e.g., fullness, masses, tenderness) • Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (e.g., masses, tenderness, organ omegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation (e.g., time, place and person) and • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Genitourinary Examination

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with a normal border.

Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes • Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Hematologic/Lymphatic/Immunologic Examination:

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with an normal border.

Musculoskeletal Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	• Examination of gait and station Examination of joint(s), bone(s) and muscle(s)/tendon(s) of **four of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, cafe-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	• Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Musculoskeletal Examination

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with an normal border.

Neurological Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Cardiovascular	• Examination of carotid arteries (e.g., pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Musculoskeletal	• Examination of gait and station Assessment of motor function including: • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)
Extremities	[See musculoskeletal]
Neurological	Evaluation of higher integrative functions including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases, spontaneous speech) • Fundamentals of knowledge (e.g., awareness of current events, past history, vocabulary) Test the following cranial nerves: • 2nd cranial nerve (e.g., visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements) • 5th cranial nerve (e.g., facial sensation, corneal reflexes) • 7th cranial nerve (e.g., facial symmetry, strength) • 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (e.g., spontaneous or reflex palate movement) • 11th cranial nerve (e.g., shoulder shrug strength) • 12th cranial nerve (e.g., tongue protrusion) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski) • Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Content and Documentation Requirements for Neurological Examination

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with an normal border.

Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., per severation, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (e.g., loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fundamentals of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements for Psychiatric Examination:

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with an normal border.

Respiratory Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Ears, Nose, Mouth and Throat	• Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass) • Examination of jugular veins (e.g., distension; a, v or cannon a waves)
Respiratory	• Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart including sounds, abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Respiratory Examination

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with an normal border.

Skin Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of any **three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat Neck	• Inspection of lips, teeth and gums • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	• Examination of liver and spleen • Examination of anus for condyloma and other lesions
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Extremities	• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following ten** areas: 1) head, including the face; 2) neck; 3) chest, including breasts, and axillae; 4) abdomen; 5) genitalia, groin, buttocks; 6) back; 7) upper right extremity; 8) upper left extremity; 9) lower right extremity; 10) lower left extremity. NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the head and neck and extremities constitutes two elements. • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis
Neurological/ Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

Content and Documentation Requirements for Skin Examination

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in a box with a bold border and at least one element in a box with an normal border.

C. Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize **four types of medical decision making**

- straight-forward
- low complexity
- moderate complexity
- high complexity

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Each of the elements of medical decision making is described below.

Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

●***DG:*** *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

● For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.

● For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.

●***DG:*** *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

●***DG:*** *If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

Amount and/or Complexity of Data to be Reviewed

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

●***DG:*** *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.*

●***DG:*** *The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

●***DG:*** *A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

●***DG:*** *Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

●***DG:*** *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

●***DG:*** *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

●***DG:*** *Co-morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

●***DG:*** *If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, e.g., laparoscopy, should be documented.*

●***DG:*** *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

●***DG:*** *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is ***minimal***, ***low***, ***moderate***, **or** ***high***. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.

The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

Table Of Risk

Level of Risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Now that you have covered all three elements of medical decision making, you can complete the final piece to selecting your level of care for a given E/M service.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	*Amount and/or complexity of data to be reviewed*	*Risk of complications and/or morbidity or mortality*	*Type of decision making*
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Now that you have completed the E/M documentation section, you should be able to select the appropriate E/M code, based on a documented level of history, examination and medical decision making. The charts below reflect an initial and established office encounter. Select the appropriate code if the key components of the service were:

History: Expanded problem focused history
Examination: Detailed examination
Medical Decision Making: Moderate complexity medical decision making

Initial Patient -Office or Other Outpatient Visit (3 of 3 Elements Must be Met or Exceeded)

LEVEL	HISTORY	EXAMINATION	MEDICAL DECISION MAKING
I	Problem focused history	Problem focused examination	Straightforward
II	Expanded problem focused history	Expanded problem focused examination	Straightforward
III	Detailed history	Detailed examination	Low complexity
IV	Comprehensive history	Comprehensive examination	Moderate complexity
V	Comprehensive history	Comprehensive examination	High complexity

LEVEL II *is the correct selection.* In this example, level II must be selected because **all three** of the key components must be at least met or exceeded to select a given level. Let's code an established patient encounter for the same elements:

History: Expanded problem focused history
Examination: Detailed examination
Medical Decision Making: Moderate complexity medical decision making

Established Patient - Office or Other Outpatient Consultation (2 of 3 Elements Must be Met or Exceeded)

LEVEL	HISTORY	EXAMINATION	MEDICAL DECISION MAKING
I	Problem focused	Problem focused	Straightforward
II	Expanded problem focused	Expanded problem focused	Straightforward
III	Detailed	Detailed	Low complexity
IV	Comprehensive	Comprehensive	Moderate complexity
V	Comprehensive	Comprehensive	High complexity

LEVEL III *is the correct selection.* In this example, level III may be selected because only **two of the three** key components are required.

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CHAPTER 7
FOCUSED MEDICAL REVIEW (FMR)

Introduction

All Medicare carriers are required to ensure that only services which are medically reasonable and necessary are paid. While it may be considered good medicine to perform tests and procedures to rule out other potential problems, the Medicare program is not designed to pay for services absent signs, symptoms or complaints necessitating those procedures. Additionally, the carrier is responsible for insuring that medically necessary services are rendered in the most cost effective manner (e.g., consideration is made to the location of the service, and the complexity and level of the care/procedure provided).

Every Medicare carrier is required to perform extensive data analysis of state utilization patterns/trends and compare them with national utilization patterns. An aberrancy occurs when utilization limits exceed what is considered to be standard medical practice, based on the utilization patterns/trends within the same specialty, peer group, etc.

In this section you will learn how physicians and/or services are trended and what Medicare does, through the focused medical review process, when utilization problems are identified which cannot be justified.

What Are Carriers Looking For?

There are generally two types of claims categories carriers review when looking for aberrancies/billing problems:

- prepaid review determinations; and
- postpaid review determinations.

Prepaid claim errors are those errors that are caught before the claim is released for payment. The claim is denied and the provider is given an opportunity to provide additional documentation to support the need for the service.

Postpaid claim errors are more difficult to detect and require sophisticated system editing capabilities and often include statistical analysis of claims data to determine "trends" for that particular provider, medical specialty or state level usage of a given procedure/service.

What Are The Goals of The Focused Medical Review Process?

An effective focused medical review process will meet the following goals:

- decrease denial rates (due to focused education);
- increase the effectiveness of newly developed local medical policies and utilization screens;
- ensure the appropriate reimbursement of Medicare services;
- change practice behavior based on education; and eliminate non-essential (or "fringe") services.

What Are The Benefits to Me As A Medicare Provider?

The focused medical review process provides the following benefits:

- Improvement in the way Medicare medically reviews claims - the process focuses on development of comprehensive medical review policies, thus the decision-making process is improved;
- Reduced hassles - providers have a better understanding of when and what Medicare needs to support a service as it relates to claim documentation;
- Predictability in claim decisions - the local carrier policies are made available to all eligible providers through carrier bulletins;
- Emphasis on education - comprehensive articles are available, and the carrier sponsors educational training.

How Are Aberrancies Identified?

Methods for identifying aberrancies vary from state to state. Medicare carriers have the option to identify aberrancies by comparing their (in this case your state's) claims data with national data. This process allows a carrier to raise a flag if the frequency for a specific procedure code is at least 150% of the national level.

Some carriers may not utilize this methodology or may not have codes which are billed above the national level. Carriers may choose other variations to determine procedure code or specialty driven aberrancies within their own state.

What is a Local Medical Review Policy (LMRP)?

Local Medical Review Policy (LMRP) is a formal document, developed through a specifically defined process, which:

- defines the service;
- provides information about when the service is considered medically necessary;
- outlines any coverage criteria and/or specific documentation requirements;
- provides specific coding and/or modifier information; and
- provides references upon which the policy is based.

Once developed and implemented, LMRP provides the decision making criteria for claim and review payment decisions.

Where Can I Find LMRPs?

Per HCFA requirements, all LMRPs are published and distributed to providers via local Medicare contractor news bulletins and publications. These publications should be kept and used as ongoing references and instructional guides when billing Medicare claims to the carrier.

Some carriers use a Medicare Bulletin Board system by which providers may access on line previously published publications.

Once Aberrancies Are Identified, What Happens With The Data?

Once an aberrant code has been identified at a specific carrier site, the carrier determines if an existing local medical policy is already in place. If a policy currently exists, the policy is evaluated to ensure that it meets current needs/standards and modified if necessary.

If a local medical policy does not exist, one is developed based on criteria developed through the carrier's medical policy department.

In cases when an aberrancy exists, the carrier will analyze the data to determine if there is a reason for the aberrancy. This is most often done by comparing your state's utilization of a particular procedure with another state's utilization which has similar incidences of illnesses/disease processes. For example, the incidence of skin melanomas is very high in Florida and California. Therefore, Florida Medicare may wish to compare the utilization of aberrant lesion removal/destruction procedure codes with California's experiences.

If the aberrancy can be reasonably explained and documented, a decision may be made not to implement any new policy. On the other hand, if the aberrancy cannot be reasonably explained and documented, the data is generally shared with the key members of the medical community to get their input on how the Medicare carrier should proceed. These members may include but are not limited to, Carrier Medical Directors (CMD) of the same or similar specialty, the Center for Disease Control (CDC), and members of the Carrier Advisory Committee (CAC). The Carrier Advisory Committee is a group of state specific physicians representing most physician specialties, who review all new local medical policies and provide input back to the carrier's medical policy department on the contents.

What Actions Are Taken If The Aberrancy Cannot Be Justified?

A carrier may get input from their Carrier Advisory Committee (CAC) members (generally from physicians representing the aberrancy) regarding suggestions on why an aberrancy may exist. The carrier will the generally conduct an extensive analysis and develop a corrective action plan. This may include, but is not limited to:

- developing and publishing local medical review policy (LMRP);
- implementing a utilization prepayment utilization screen - the Medicare carrier will allow up to a specified number of those procedures within a designated period of time. Services billed in excess of the designated screen will require the physician to submit medical documentation supporting the services provided;
- implementation of a diagnosis to procedure code edit - the procedure would be allowed only if performed for a specified diagnosis or symptom;
- publishing an article on the policy for that procedure(s);
- referral of an individual provider (who is contributing largely to the aberrancy) for a comprehensive medical review. In such cases, the targeted physician would be asked for medical records justifying payment for services rendered. Depending on the results, an overpayment may be assessed and applied historically to the universe of the provider's services; and
- referral of the individual provider(s) to the carrier's fraud unit if Medicare fraud and/or abuse is suspected.

What Are The Most Common Types of Aberrancies Medicare Has Found?

Some aberrancies identified by Medicare carriers include:

- provider errors in billing indicating incorrect patients for a service billed;
- billing for excessive, not medically necessary diagnostic procedures or visits;
- incorrect or omitted modifiers;
- filing duplicate claims; and
- use of incorrect CPT as compared to actual services rendered.

How Can I Be Proactive With LMRPs In My Office or Facility?

- Review and read all carrier publications and news bulletins containing LMRPs and become knowledgeable about the coverage requirements;
- Ensure that your staff and billing vendors are familiar with claim filing rules associated with any LMRP which affects your specialty;
- Create an educational awareness to your Medicare patients that helps them understand any specific coverage limitations or medical necessity requirements for those services you provide;

- Work with your claims submission vendors to incorporate LMRP edits; and
- Perform mock record audits to ensure that your documentation reflects the requirements outlined in the LMRP.

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CHAPTER 8
OTHER LEGISLATIVE ISSUES THAT AFFECT MEDICARE PAYMENT

This section is designed to help providers understand the various laws that affect Medicare coverage.

Clinical Laboratory Improvement Amendments

The Clinical Laboratory Improvement Amendments (CLIA) of 1988, Public Law 100-578, amended §353 of the Public Health Service Act (PHSA) to extend jurisdiction of the Department of Health and Human Services to regulate all laboratories that examine human specimens to provide information to assess, diagnose, prevent, or treat any disease or impairment. Under CLIA, any provider who performs clinical laboratory tests and certain other diagnostic services must obtain the appropriate certification from the Health Care Financing Administration (HCFA). These regulations are designed to set quality and performance standards for all laboratory testing.

There are three categories of certification under the CLIA program:

- **Waived test certificates** are issued to providers who perform tests that are considered to be simple tests which can be performed with minimal supervision and, if performed erroneously, pose little or no risk to the patient.

- **Non-waived test certificates** are issued to providers who perform complex tests and procedures which require specific certification of the staff and equipment used in their performance, and pose significant risk or danger to the patient if performed incorrectly.

- **Physician performed microscopy procedure (PPMP) certificates** are issued to physicians who perform various specimen examinations in addition to the simpler waived tests. The microscope is the only instrument that may be used. Your local Carrier can supply you with a list of PPMP tests.

Upon certification, each laboratory is assigned an individual and unique CLIA number. Each CLIA number consists of ten digits/positions:

- positions 1 and 2 are the State code (based on the laboratory's location at time of registration);
- position 3 is an alpha letter "D" (for all labs); and
- positions 4-10 are a unique number assigned by the CLIA billing system (no other laboratory in the country has this number).

Beginning in January 1998, the CLIA number must be on all claims for laboratory services or the service(s) will be returned as unprocessable. The CLIA number can be entered in block 23 of the HCFA-1500 claim form or the applicable electronic field.

CLIA regulations are not specific only to the Medicare program, but were enacted by Congress on a national scale. These provisions apply to all providers who render clinical laboratory and certain other diagnostic services, regardless of whether they file claims to Medicare.

Guidelines for Teaching Physicians [IL372]

Effective for all services rendered on and after July 1, 1996, revised guidelines have been established by the Health Care Financing Administration (HCFA) for teaching physicians (i.e., physicians [not a resident] who involve residents in the care of their patients).

These guidelines require the presence of a teaching physician during the key portion of the service in which a resident is involved and for which contractor payment will be sought. In the case of surgical, high risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure.

Medicare will pay for physician services furnished in teaching settings under the physician fee schedule only if:

- The services are personally furnished by a physician who is not a resident; or
- The services are furnished jointly by a teaching physician and resident or by a resident in the presence of a teaching physician with certain exceptions that need to be determined on a case by case basis.

"Incident to" Provision

Medicare Part B covers services rendered by employees of physicians or physician directed clinics when the services provided are an integral, although incidental, part of the physician's professional service. To meet the requirements of this provision for services billable to the contractor, certain conditions must be met:

- The services and supplies are commonly furnished in an office; and
- The services are furnished as an integral, although incidental, part of the physician's professional services in the course of the diagnosis or treatment of an injury or illness and require direct personal physician supervision; and
- A valid employment arrangement must exist between the physician/clinic and the employee. This may be accomplished by employing a full-time, part-time or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician.

Office Setting Or Physician Directed Clinic

These services are rendered under direct supervision of the physician (the physician must be in the office or office suite and immediately available to provide assistance to the employee providing the service).

Services in An Institution Or Other Facility Setting

This setting presents a special problem in determining whether direct physician supervision exists when the non-physician services are rendered in a facility, but outside the physician's office.

Medicare cannot assume the physician and non-physician will be in close proximity to one another. Therefore, the services of the employee can be covered only if the physician accompanies him/her to treat the patient and directly supervises the services. Thus, in effect, the physician is providing "over the shoulder" supervision.

Services provided by the physician's auxiliary staff in the hospital setting are covered as part of the Part A hospital stay and therefore are not reimbursed by Medicare Part B to the physician.

Home Care

The same rules which apply in an office setting would carry over in the patient's personal residence, if the physician is present. However, certain rules apply if the physician is not present at the patient's home.

Medicare can reimburse services provided "incident to" a physician's professional service(s) in the patient's home when certain conditions are met:

- The patient resides in a medically under served* area and no Home Health Agency operates in the patient's area and is available in a timely manner. *(A list of medically under served areas is available through your local Medicare contractor); and
- The patient is homebound and unable to travel for routine medical services;
- The employee is under general supervision of the physician. (This means the physician must be immediately available by telephone to collaborate with the employee providing the service.); and
- Only limited, defined services can be provided in the patient's home.

Only those services supervised (either direct or over the shoulder) by the physician are billable to Medicare. Any non-supervised services are not billable to Medicare nor the patient. All requirements noted in the office setting also apply to services in a facility setting.

Services by Non-Physician Practitioners

There are separate provisions of Medicare law which allow coverage for services furnished by non-physician practitioners (e.g., nurse practitioners, physician assistants, licensed clinical social workers, etc.) without the direct supervision of a physician. When the non-physician practitioner renders services which are not under direct supervision, specific coverage restrictions and/or billing requirements may apply.

For example, modifiers may be required for billing or the scope of coverage may be limited based on licensure and state requirements.

Nonetheless, if services by non-physician practitioners are to be reported and covered under the "incident to" provision, then the requirement of direct physician supervision applies as well as all the other "incident to" requirements.

Mandatory Claims Filing Requirements

The Omnibus Budget Reconciliation Act of 1989 requires that you submit claims for all your Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries. **You may not charge your patients for preparing or filing a Medicare claim. The requirement to submit Medicare claims does not mean you must accept assignment.** Compliance of the claims mandatory claim filing requirements are monitored by carriers. Violations of the requirement may be subject to a civil monetary penalty of up to $10,000 for each violation.

What Are the Exceptions to Mandatory Filing?

You are not required to file claims on behalf of Medicare beneficiaries for:

- used DME purchased from a private source;
- MSP when you do not possess all the information necessary to file a claim;
- foreign claims;
- services billed to the third party insurers (indirect payment provisions);
- opting out of the Medicare Program by signing private contracts with Medicare beneficiaries; and
- other unusual services evaluated by the carrier on a case-by-case basis.

Note: You are not required to file non-covered Medicare services, however, you are encouraged to do so since many Medicare supplemental insurance policies pay for services that Medicare does not allow. These companies usually require a denial notice.

If you do not accept assignment on a Medicare claim, the Privacy Act prohibits the carrier from releasing certain claims information to you. The only information releasable about a claim is if it has been received, paid or its status in the Medicare processing system. Other, more specific, information cannot be released unless the patient authorizes

the release of such information. Limited status of nonassigned claims and complete status of assigned claims can be obtained by contacting your local Medicare carrier.

Private Contracting with Medicare Beneficiaries

Section 4507 of the BBA permitted, effective January 1, 1998, certain physicians and practitioners (under the limited definition for this purpose) to privately contract with Medicare beneficiaries if the physician or practitioner files an affidavit with Medicare opting out of Medicare for 2 years.

Section 4507 of the Balanced Budget Act provisions allows:

- physicians or practitioners to sign private contracts with Medicare beneficiaries;
- agree not to file claims to Medicare or any other organization which receives reimbursement from Medicare - unless the service is for emergency or urgent care which would require the use of modifier **GJ** (Opt-Out Physician or Practitioner Emergency or Urgent Service);
- contracts must be written and signed by the beneficiary before any item or service is provided (pursuant to the contract);
- the contract must clearly indicate to the beneficiary that by signing the contract he/she:

  - Agrees not to submit a claim to Medicare;
  - Agrees to pay the provider for the service;
  - Agrees to pay "full-fee" for the service with no limits on amount;
  - Acknowledges that supplemental insurance may not make payment because Medicare will not make payment;
  - Acknowledges that the beneficiary can choose to go to another physician and have Medicare reimburse for the services and the contract would have to clearly indicate whether the physician is excluded from Medicare.

- the physician must file an affidavit with the Medicare contractor acknowledging that they will not file any claims with Medicare for two years beginning on the date the affidavit was signed;
- if the physician violates any of these provisions, they will not be able to enter into any additional private contracts during the two period, nor could they count on any reimbursement from Medicare for their services.

Anti-Fraud Provisions

In May 1995, President Clinton announced a new partnership between federal and state agencies to crack down on Medicare and Medicaid fraud, waste, and abuse. The targeted anti-fraud project, known as **Operation Restore Trust (ORT)**, initially focused on New York, Florida, Illinois, Texas, and California. These states account for approximately 40 percent of all Medicare and Medicaid beneficiaries. ORT has expanded to include other states as well.

The Department of Health and Human Services (DHHS) is leading these efforts. In addition, the Health Care Financing Administration (HCFA), the Office of the Inspector General (OIG), the Administration on Aging (AOA), the Department of Justice (DOJ), and the Medicare contractors participate in ORT.

False Claims Act

The False Claims Act prohibits knowingly filing a false or fraudulent claim for payment to the government, knowingly using a false record or statement to obtain payment on a false or fraudulent claim paid by the government, or conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

See 31 U.S.C. 3729(a) of the Act for additional details/exclusions/statutory exceptions.

The Anti-kickback Statute

The Anti-kickback Statute prohibits:

- Soliciting or receiving remuneration for referrals of Medicare or Medicaid patients, or referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid;
- Soliciting or receiving remuneration in return for purchasing, leasing, ordering, or arranging for, or recommending purchasing, leasing, or ordering any goods, facility, service or item for which payment may be made in whole or in part, by Medicare or Medicaid;
- Offering or paying remuneration for referrals of Medicare or Medicaid patients or for referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid;
- Offering or paying remuneration in return for purchasing, leasing, ordering, arranging for or recommending purchasing, leasing, or ordering any goods, facility, service or item for which payment may be made, in whole or in part, by Medicare or Medicaid; and
- Discounts, rebates, or other reductions in price may violate the anti-kickback statute because such arrangements induce the purchase of items or services payable by Medicare or Medicaid. However, certain arrangements are clearly permissible if they fall within a "safe harbor."

Safe Harbors

Safe harbor provisions protect certain individuals, providers or entities from criminal prosecution and/or civil sanctions (when certain requirements are met) for actions which may appear as unlawful or inappropriate according to Medicare law.

The Department of Health and Human Services established the "Safe Harbors for Protecting Health Plans" in accordance with the Medicare and Medicaid Patient and Program Protection Act of 1987 (as published in the November 5,

1992 Federal Register). The safe harbors are updated annually to consider changes to medical delivery systems and new financial relationships. Comprehensive information on the safe harbor provisions can be obtained from the Code of Federal Regulations (42 CFR 1001.92). The safe harbors provision includes:

- protection for certain incentives to enrollees (including waiver of coinsurance and deductible amounts) paid by health care plans; and
- protection for certain negotiated price reduction agreements between health care plans and contract health care providers.

Physician Self-Referral (Stark II) Laws

In January 1995, Congress passed a law which prohibits certain physician self-referrals in the context of the Medicare and Medicaid programs. Section 1877 of the Social Security Act (42 USC Section 1395nn) states that physicians cannot make self-referrals for certain designated health services (DHS). DHS include any of the following items or services:

- clinical laboratory services;
- physical therapy services;
- occupational therapy services,
- radiology services;
- radiation therapy services and supplies;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient/outpatient hospital services.

What Does Stark II Prohibit?

The law prohibits a physician or his immediate family members from having a financial relationship with an entity to which Medicare patients are referred to receive a designated health service. A financial relationship can exist as an ownership or investment interest in or a compensation arrangement with an entity.

Penalties for Violating the Law

The civil monetary penalty is a maximum of $15,000 for each service billed or furnished as the result of a prohibited referral. A total maximum penalty of $100,000 can be applied for each scheme to evade the requirement.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as the Kennedy-Kassebaum bill, was enacted on August 21, 1996. Among other provisions, the Act is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. The Act also imposes significant changes to anti-fraud and abuse activities. These provisions of HIPAA use a four-pronged approach to combat health care fraud, waste, and abuse:

- education;
- extended coverage;
- enhanced enforcement; and
- expanded penalties.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 was signed into law on August 5, 1997. The law makes numerous changes to the various titles of the Social Security Act.

The Act includes several anti-fraud and abuse provisions and improvements in protecting program integrity. The following are some of the provisions:

Permanent Exclusions

This provision excludes from Medicare or any State health care program for at least 10 years, an individual who has been convicted on one previous occasion of one or more health care related crimes for which a mandatory exclusion could be imposed, including Medicare and state health care program related crimes, patient abuse, or felonies related to health care fraud or controlled substances. It also permanently excludes an individual who has been convicted on two or more previous occasions of such crimes.

Authority to Refuse to Enter Into Agreements

This provision authorizes the DHHS to refuse to enter into, renew an agreement or terminate an agreement with a provider if the provider has been convicted of a felony under Federal or State law for an offense which the DHHS determines is inconsistent with the best interests of the program or program beneficiaries.

Exclusion of Entity Controlled by Family Member

This provision authorizes the DHHS to exclude from Medicare or any State health care program, those entities where a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following a conviction, assessment, or exclusion.

Imposition of Civil Monetary Penalties

This provision provides that a civil monetary penalty of up to $10,000 may be levied when a person arranges or contracts with an individual or entity for the provision of items or services when it knows or should know that the individual or entity has been excluded from a federal health care program. The individual or entity would also be subject to an assessment of up to three times the amount claimed and to exclusion from Federal health care programs.

A civil monetary penalty of up to $50,000 plus up to three times the amount of remuneration offered, paid, solicited or received could be levied for each violation of the anti-kickback provisions.

Anti-Fraud Message in Medicare Handbook

This provision states that the Medicare Handbook must contain:

- a statement indicating that errors occur and that Medicare fraud, waste and abuse is a significant problem;
- statements encouraging beneficiaries to review their Medicare Summary Notices or statements for accuracy and to report any errors or questionable charges;
- a description of a beneficiary's right to request an itemized statement from their provider for Medicare items and services;
- a description of the beneficiary Incentive Reward Program established under HIPAA; and
- DHHS OIG toll-free hotline number which receives complaints and information about fraud, waste, and abuse.

Disclosure of Information and Surety Bonds

This provision states that durable medical equipment (DME) suppliers, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs) and rehabilitation agencies would be required to provide a surety bond of at least $50,000.

DME suppliers would also be required to identify each person with an ownership or controlling interest in the supplier or any subcontractor in which the supplier has a direct or indirect ownership interest of five percent or more.

Beneficiary Right to Itemized Statements

This provision gives Medicare beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any item or service furnished. Providers/suppliers must furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of not more than $100 for each unfullfilled request. In addition, the provider/supplier may not charge the beneficiary for the itemized statements.

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CHAPTER 9
FRAUD AND ABUSE

Each year fraud and abuse in the Medicare program accounts for a substantial percentage of Medicare's annual spending. The estimated costs for Medicare fraud and abuse exceed $12 billion each year. In recent years, that estimate was as high as $23 billion. However, as a result of legislation which focuses on health care fraud and the federal government's commitment to combatting it, this amount was reduced through increased prevention, education, detection, and enforcement.

The Health Care Financing Administration (HCFA) is emphasizing the prevention and early detection of fraud and abuse which may be identified by multiple sources including providers, beneficiaries, and other government agencies.

The billions of taxpayer dollars lost to health care fraud and abuse are the financial resources that should be used to pay for services that keep beneficiaries in good health. The Medicare contractors are aggressively working with the Health Care Financing Administration, the Federal Bureau of Investigations (FBI), the Office of the Inspector General (OIG), the Medicaid Fraud Control Unit, and the United States Attorney's Office in dealing with these issues. In addition, Medicare is interacting with many provider and beneficiary advocacy associations to provide ongoing outreach education.

This chapter is designed to inform Medicare providers and healthcare organizations about the delicate situations they may encounter concerning potential fraud and abuse of the Medicare program.

Medicare Is On Your Side

If this chapter raises questions in your mind about fraud and abuse or if you want to report what you believe are fraudulent or abusive activities, please contact Medicare and become a part of the solution.

Additionally, providers and healthcare organizations must be proactive in staying abreast of these issues to avoid becoming a victim themselves.

Anyone who suspects or would like to report potential fraud and abuse, should call or write to the local Medicare contractor, or contact the OIG National Hotline directly at: **1-800-HHS- TIPS.**

Although reports may be used during an investigation, they are held in the strictest confidence. Reports can also be made anonymously.

Internet Access

The entire Government Services Administration (GSA) debarment, exclusion, and suspension list is accessible on the Internet at:

www.arnet.gov/epls/

This web site is updated daily to assist Medicare and Medicaid contractors when verifying the eligibility of health care providers and/or entities seeking to participate in the Medicare and Medicaid programs. Medicare encourages individuals and entities to research the information on this web site before adding a provider to a physician group or a medical staff, purchasing or considering involvement in a medical facility or other entity that may seek payment from the Medicare program.

The Department of Health and Human Services (DHHS) also has an internet website that not only includes a database of sanctioned providers, but also information related to HCFA and OIG updates. It is accessible on the internet at the following address:

www.hhs.gov

General Information

The Medicare program has become big business and has attracted - as big businesses sometimes do - a few unsavory characters. It is becoming more important than ever for providers to be cautious. This section is provided to help readers "stay on their toes" by:

- enhancing their understanding of what Medicare fraud/abuse is and isn't;
- explaining the penalties that can be levied when fraud/abuse is committed; and
- providing guidance on protective measures that can be implemented to avoid fraud/abuse in several key areas of their health care organization.

What Is Fraud?

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Examples of Fraud

- billing for services not rendered;
- soliciting, offering, or receiving a kickback, bribe, or rebate;
- using an incorrect or inappropriate provider number in order to be paid (e.g. using a deceased provider's number);

- signing blank records or certification forms that are used by another entity to obtain Medicare payment;
- selling or sharing patients' Medicare numbers so false claims can be filed;
- offering incentives to Medicare patients that are not offered to non-Medicare patients (e.g., routinely waiving or discounting the Medicare deductible and/or coinsurance amounts);
- falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government; and
- misrepresenting as medically necessary, non-covered services by using inappropriate procedure or diagnosis codes.

What Is Abuse?

Abuse may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Although many types of inappropriate practices may be considered abusive, they may evolve into fraud.

Examples of Abuse

- using procedure or revenue codes that describe more extensive services than those actually performed;
- collecting more than the 20% coinsurance or the deductible on claims filed to Medicare. Providers may, of course, bill patients for services not covered (e.g., service exclusions);
- routinely submitting duplicate claims;
- billing for services grossly in excess of those needed by patients. For example, always billing for complete lab profiles when only a single diagnostic test is necessary to establish diagnosis;
- incorrectly apportioning costs on cost reports for Part A providers; and
- charging more than the actual purchase price of a service, item, or drug.

Actions That May Be Against Providers or Entities Who Commit Fraud or Abuse

When Medicare determines that fraud potentially exists, the case is developed via research and investigation then it is referred to the Office of Inspector General (OIG) or other law enforcement agency (e.g., FBI) for further investigation. The OIG then coordinates its investigation with other federal and state law enforcement agencies.

The following list describes actions that may be taken when fraud or abuse is identified.

Criminal Prosecutions & Penalties

Because it is a federal crime to defraud the United States Government or any of its programs, an individual may be sent to prison, fined or both. Criminal convictions usually include restitution and significant fines. In some states, providers and healthcare organizations may also lose their licenses. Convictions mandatorily result in exclusion from Medicare and other federal health care programs for a specific length of time.

Depending on the case, the U.S. Attorney's Office may use a variety of statutes to indict and prosecute the individuals and/or entities involved. Sometimes, a combination of two or more of the statutes may be used. Some of them are listed below:

- 18 U.S.C. Section 1347: Health care fraud
- 18 U.S.C. Section 669: Theft or embezzlement in connection with health care
- 18 U.S.C. Section 1035: False statements relating to health care
- 18 U.S.C. Section 1518: Obstruction of a Federal health care fraud investigation
- 18 U.S.C. Section 371: Conspiracy to commit fraud
- 18 U.S.C. Section 287: False claims
- 18 U.S.C. Section 1001: False statements
- 18 U.S.C. Section 201: Bribery
- 42 U.S.C. Section 1320: Kickbacks
- 18 U.S.C. Sections 1956-57: Money laundering
- 18 U.S.C. Section 1962: RICO Act
- 18 U.S.C. Section 1343: Wire fraud
- 18 U.S.C. Section 1341: Mail fraud

Civil Prosecutions & Penalties

In addition to or in lieu of criminal prosecutions, the U.S. Attorney may file a civil suit or may decide that the interest of the program is best served by settling the case. In these situations, the amount of damages plus additional money is paid to the government in the form of penalties and fines. These penalties may also include a permissive exclusion, which translates into not being permitted to bill Medicare and Medicaid for a specified number of years.

Civil Monetary Penalties

The Medicare and Medicaid Patient and Program Protection Act of 1987 authorizes the imposition of civil monetary penalties when it is determined that a person or entity has violated Medicare laws by submitting claims that cause violation of any of the following:

- violation of the Medicare assignment provisions;
- a Medicare physician or supplier agreement violation;
- false or misleading information expected to influence a discharge decision;
- violation of assignment requirement for certain diagnostic clinical laboratory tests;

- violation of requirement of assignment for nurse-anesthetist services;
- any supplier who refuses to supply rental durable medical equipment (DME) supplies without charge after rental payments may no longer be made;
- physician billing for assistants at cataract surgery without prior approval of the Peer Review Organization (PRO);
- hospital unbundling of outpatient surgery costs; and
- hospital and responsible physician "dumping" of patients, based upon their inability to pay or lack of resources.

Typically, penalties involve assessments of significant damages (fines) and could also include exclusion from the Medicare program.

Actions Resulting from Kickbacks, Bribes, False Statements, and Rebates

Whoever ...

- knowingly and willfully makes or causes to be made any false statement or representation of material fact in an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
- has knowledge of any event affecting his/her right to receive a benefit or affecting the right of another individual in whose behalf he/she receives such benefit, and fails to disclose such event with the intent to fraudulently secure greater amount or quantity than is due or when none is due;
- receives benefits on behalf of another person and knowingly and willfully puts them to a use other than for the benefit of that person; or
- furnishes items or services and solicits, offers, or receives a kickback, bribe or rebate of a fee...

... shall be guilty of a felony and upon conviction, shall be fined not more than $50,000 per violation or imprisoned for not more than five years per violation, or both.

Exclusion Authority

The OIG under the Department of Health and Human Services has the authority to exclude providers who have been convicted of a health care related offense. A mandatory exclusion exists if there is a conviction of fraud. In the absence of a conviction, the OIG may permissively exclude providers if certain conditions and requirements have been met. Even when the U.S. Attorney's Office declines to prosecute a case, the OIG may take action to exclude the provider from the Medicare program. Exclusion means that for a designated number of years, Medicare, Medicaid and other government programs will not pay the provider for services performed or for services ordered by the excluded party.

Mandatory Exclusions

Section 1128(a)(1) - Program related conviction

The OIG is required to exclude individuals and entities that have been convicted of a crime relating to the abuse or neglect of patients in connection with the delivery of a health care item or service.

Section 1128(a)(2) - Conviction for patient abuse or neglect

The OIG is required to exclude individuals and entities that have been convicted of a crime relating to the abuse or neglect of a patient. The minimum mandatory period of exclusion for these types of convictions is five years.

Section 1128(a)(3) - Felony conviction relating to health care fraud

The OIG is required to exclude individuals and entities that have been convicted for an offense which occurred after the date of enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or state law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in Section 1128(a)(1)) operated by or financed in whole or in part by any Federal, state or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

Section 1128(a)(4) - Felony conviction relating to controlled substance

The OIG is required to exclude individuals and entities that have been convicted for an offense which occurred after the date of enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or state law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Permissive Exclusions

Section 1128(b)(1) - Conviction relating to fraud

The OIG may exclude any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or state law, of certain types of crimes that either could be or could not be related to the delivery of items or services under Medicare or any state health care programs. Convictions for a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct are covered by this section.

Section 1128(b)(2) - Conviction relating to obstruction of an investigation

The OIG may exclude any individual or entity convicted under Federal or State law of interference with, or obstruction of, any investigation into a criminal offense involving program-related convictions (sections 1128(a)(1) or (a)(2)) or fraud (section 1128(b)(1)). Some of the types of convictions covered by this section are perjury, witness tampering, and obstruction of justice.

Section 1128(b)(3) - Misdemeanor conviction relating to controlled substances

The OIG may exclude any individual or entity convicted of a misdemeanor criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. OIG limits sanctions under this authority to those individuals or entities that have a relationship to any health care activity.

Section 1128(b)(4) - License revocation or suspension

The OIG may exclude any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any state licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity; or
(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

The term "otherwise lost" is intended to cover any situation where the effectiveness of the person's license to provide health care has been interrupted or precluded, regardless of the term used in a particular jurisdiction.

Section 1128(b)(5) - Suspension or exclusion under a Federal or State health care program

The OIG may exclude any individual or entity suspended or excluded from participation, or otherwise sanctioned, by a State health care program or any other Federal program involving the provision of health care for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity. The phrase "otherwise sanctioned" is intended to cover all actions which limit the ability of a person to participate in the program at issue, regardless of what such a sanction is called.

Section 1128(b)(6) - Excessive claims or furnishing of unnecessary or substandard items or services

The OIG may exclude an individual or entity which submits excessive claims, or furnishes unnecessary or substandard items or services, not only to Medicare and State health care program beneficiaries, but to any person. This section also provides for the exclusion of Health Maintenance Organizations and similar types of entities for failure to provide medically necessary items and services, where such failure has adversely affected, or has a substantial likelihood of adversely affecting, beneficiaries.

Section 1128(b)(7) - Fraud, kickbacks and other prohibited activities

The OIG may exclude any individual or entity that it determines knowingly and willfully solicited, received, offered, or paid any remuneration, i.e., fraud, kickbacks, and other prohibited activities.

Section 1128(b)(8) - Entities controlled by a sanctioned individual

OIG may exclude entities if they are controlled by individuals who have been convicted, who have had civil monetary penalties or assessments imposed against them, or who have been excluded from any of the programs under any exclusion authority.

Section 1128(b)(9) - Failure to disclose required information

The OIG may exclude any entity that did not fully, accurately, and completely make disclosures about individuals who have been convicted of theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct who are associated with that entity.

Section 1128(b)(10) - Failure to supply requested information on subcontractors and suppliers

The OIG may exclude entities who fail to respond to an OIG request for information on subcontractors and suppliers.

Section 1128(b)(11) - Failure to provide payment information

The OIG may exclude any individual or entity providing services to program beneficiaries if the party fails to provide payment information or refuses to permit examination and duplication of payment records in order to verify the information contained therein.

Section 1128(b)(12) - Failure to grant immediate access

The OIG may exclude any individual or entity that fails to grant immediate access upon reasonable request to certain agency representatives for review of documents related to performance of their statutory functions.

Section 1128(b)(13) - Failure to take corrective action

The OIG may exclude any hospital that HCFA determines failed substantially to comply with a corrective action plan

required by HCFA. The HCFA regional office will provide the necessary information to the OIG who will then take the exclusion action.

Section 1128(b)(14) - Default on health education loans or scholarship obligations

The OIG may exclude any individual that the Public Health Service determines to be in default on repayments of scholarship obligations or loans.

Section 1128(b)(15) - Individuals controlling a sanctioned entity

OIG may exclude any individual who has ownership or controlling interest in a sanctioned entity and who knows or should know of the action constituting the basis for the conviction or exclusion of the entity. This includes civil monetary penalties or assessments or exclusion by any of the programs under any exclusion authority.

Sanctioned and Reinstated Provider Lists

The OIG identifies individuals and entities that are excluded from reimbursement under Medicare through sanctioned provider lists. In addition to the identifying information pertaining to the sanctioned party, the list includes the specialty, notice date, sanction period, reason for sanction being imposed, and the sections of the Social Security Act used in arriving at the determination to impose a sanction. The OIG also lists the individuals and entities that have been reinstated to the Medicare program. This information is available on the internet web site, **www.arnet.gov/epls/.**

Payment Denials

Denial of Payment to an Excluded Party

Medicare payment will not be made to any excluded provider for items or services furnished, ordered or prescribed on or after the effective date of the exclusion.

Denial of Payment to a Supplier

Medicare payment will not be made to a supplier (e.g., durable medical equipment supplier or laboratory) that is wholly owned by an excluded party for items and services furnished on or after the effective date of the sanction.

Denial of Payment to a Provider of Service

Medicare payment will not be made to a provider for services performed or items received, including services performed under contract, by an excluded party or by a supplier which is wholly owned by an excluded party on or after the effective date of the sanction.

Denial of Payment to Beneficiaries

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier which is wholly owned by an excluded party on or after the effective date of the sanction:

- Medicare payment may be made for the first claim submitted by the beneficiary and the Medicare program will immediately give the beneficiary notice of the sanction; and
- The Medicare program will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary.

Exceptions

Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

- inpatient hospital services or post hospital skilled nursing facility services or items furnished to a beneficiary who was admitted to a hospital or skilled nursing facility before the effective date of the sanction; and
- home health services or items furnished under a plan of treatment established before the effective date of the sanction.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P. L. 100-93) does permit payment for an emergency item or service furnished by an excluded individual or entity.

Reinstatement

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare program and may apply to the OIG for reinstatement.

Whistle Blower Cases

The "Whistle Blower", or "*qui tam*" provision as it is formally called, allows persons having knowledge of a false claim against the government to bring an action against the suspected wrong doer on behalf of the United States Government. Any person who files a *qui tam* suit on behalf of the government, known as a "relator," may share a percentage of the recovery realized from a successful action.

Incentive Reward Program

As a result of the Health Insurance Portability and Accountability Act of 1996, a program was established to encourage individuals to report information on individuals and/or entities who are or have been engaged in fraudulent activities that could result in sanctions under any federal health care program.

Under the Incentive Reward Program, Medicare may make a monetary reward for information that leads to a minimum recovery of $100 of Medicare funds that were inappropriately obtained. The amount of the reward can be 10 percent of the amount recovered or $1000, whichever is less.

Contractor and HCFA Actions

In addition to the possible actions that may be taken by the federal government such as prosecutions, the contractor and HCFA also have a responsibility to ensure that all claims paid are appropriate.

Suspension of Payments

In January 1997, HCFA assumed the responsibility to suspend payments to any provider if fraud is suspected or if a potential overpayment exists and there is reasonable evidence that the overpaid amounts would not be refunded. HCFA instructs the contractor to withhold all monies for claims approved for payment up to 180 days. If, after the first 180 day period, fraud is still suspected, HCFA can authorize the contractor to continue to withhold payments for an additional 180 days. If, after the first year, fraud is still suspected, the U.S. Attorney, through HCFA, can instruct the contractor to withhold all payments to a particular provider or entity indefinitely. The provider or entity may submit rebuttals for suspension actions in cases of suspected fraud directly to HCFA for consideration in lifting the suspension.

In cases where Medicare has evidence that an overpayment may not be repaid by a provider, the contractor may withhold payments until the overpaid amounts are recovered. Rebuttals to this suspension activity should be directed to the contractor.

Flag or Focus Review

The contractor may decide to review a provider's claims *prior to payment.* In cases of this type of prepayment review (called *focus* for Part A providers and *flag* for Part B providers), the provider is notified by Medicare and instructed as to what type of documentation is needed for a detailed review of the claims.

Comprehensive Overpayments

Often, Medicare determines that an entire organization will be reviewed. In these cases, a letter requesting specific documentation for selected codes and/or patients is sent to the provider. Once received, the documentation is used to determine if an overpayment exists.

Education

In many instances, inappropriate billings or patterns of errors can easily be corrected by education. If it is determined that a provider may not understand billing and/or coverage guidelines and it is apparent that there is no fraud involved, the contractor may initiate or suggest an educational plan or corrective action plan for the provider so that they can become compliant with Medicare guidelines.

Protect Yourself

The following situations should be approached with caution to ensure that Medicare guidelines are followed.

Provider Enrollment Department

Nationally, provider enrollment departments have taken active roles in protecting the Medicare program from potential fraud and abuse. Since 1995, carriers now conduct on-site visits to providers' offices and facilities. The purpose of these visits is to verify the information supplied on the provider's application to Medicare. Although granting access to this Medicare representative is voluntary, failure to allow access may result in denial of an application for a provider number or the cancellation of a current Medicare provider number.

During these visits, the Medicare representative may request to view all required federal, state, county or local licenses. Medicare providers are required to obtain and maintain such licenses and have them available for review by a Medicare representative.

If there are any changes to information included in original applications for Medicare provider numbers, notify the applicable provider enrollment department. Examples of such changes may include: address change, change of ownership, change in the name of the business, or change in the Tax ID#. Failure to provide notification may result in temporary cancellation of the provider number thereby preventing payments from Medicare.

Reassignment of Benefits

Medicare must make payment directly to the physician or other supplier who furnished the service(s) except in the following situations:

Payment to employer - Medicare may pay the employer of a physician or other supplier if the physician or other supplier is required, as a condition of their employment, to turn over to their employer the fees for the services.

Payment to facility - Medicare may pay the facility in which the service was furnished if there is a contractual arrangement between the facility and other supplier under which the facility bills and receives payment for the services.

Payment to health care delivery systems - Medicare may make payment to a health care delivery system if there is a contractual arrangement between the system and the physician or other supplier under which the system bills for the physician's or other supplier's services. In order to be considered a health care delivery system, an organization must be either a clinic, a carrier dealing prepayment organization, a direct dealing health care prepayment plan, or a direct dealing HMO or competitive medical plan.

For the purpose of receiving payment under reassignment as

a health care delivery system, a clinic must be a freestanding entity which provides diagnostic and/or therapeutic medical services on an outpatient basis in quarters which it owns or leases. The clinic would be able to bill and receive payment for services of independent contractor physicians for services provided on the clinic's premises. For services provided off the premises, either the physician must bill directly to Medicare or the facility where the services were provided must bill under their name and number.

The Health Care Financing Administration (HCFA) developed the following definition for a medical group: "*Two or more physicians, non-physician practitioners or other health care providers/suppliers who form a practice together (as authorized by State law) and wish to bill Medicare as a unit. This excludes contracted physicians, non-physician practitioners and other contracted health care providers/suppliers. A group has individual members. The individual members must be enumerated and enroll in the Medicare program as an individual in order to enroll as a member of the group. A group can only be enrolled if it can meet the conditions for reassignment.*"

Medicare has developed stringent criteria which must be met in order to allow a physician to reassign their Medicare benefits to a health care delivery system. If it is determined that the criteria are not met, the request may be denied (in case of a new application), or the physician's eligibility to reassign their benefits to a particular facility will be terminated if previously allowed.

Non-physicians may also reassign their benefits to a health care delivery system. The group or clinic for which they wish to reassign their benefits must meet the established criteria for a health care delivery system.

There have been many questions raised as to whether a physician may reassign Medicare benefits to an agent who is acting on behalf of the physician. Medicare laws do not allow a reassignment of benefits to an agent, but the Medicare Program may make payment in the name of the physician (or other supplier or party eligible to receive the payment) to an agent who furnishes billing or collection services if:

- the agent receives the payment under an agency agreement with the physician;
- the agent's compensation is not related in any way to the dollar amounts billed or collected;
- the agent's compensation is not dependent on the actual collection of payment;
- the agent acts under payment disposition instructions which the physician may modify or revoke at any time; and
- in receiving the payment, the agent acts only on behalf of the physician (except insofar as the agent uses part of that payment to compensate the agent for the agent's billing and collection of services).

Choosing a Billing Service

A billing service is a company that generally handles claim filing to various insurance companies for provider offices. A billing service may charge the provider based on either a per-claim charge fee or a percentage-of-total-claim-amount fee.

Some billing services may collect paper claims from the provider's office, perform the appropriate coding for the services rendered, and then forward the claims electronically to the carrier from their host computer systems. Other billing services supply the provider with billing software and/or a computer terminal for claims entry and submission to the billing service host computer, which then forwards the claims to the appropriate insurance company.

Remember: physicians and entities are responsible for the accuracy of all services billed even when they utilize billing consultants and clearhouse vendors.

Questions to Ask When Selecting a Billing Service

The following section has been added to assist you with general information or guidelines you should consider when selecting a billing service.

Contractual Arrangements

Become familiar with the types of agreements or paperwork needed to be executed between you and the billing service you select. If uncertain, contact your legal counsel for further discussion.

You may also want to know if there are any agreements or paperwork required between you and the insurance companies (e.g., an Electronic Data Interchange [EDI] agreement is required by Medicare Part B for your protection.)

Convenience

As with any service, convenience is certainly a consideration which could be considered when choosing a billing service. Questions you may want to ask include:

- How will the claims be transported or submitted from the physician's office to the billing service?
- Do I need to mail completed paper claims to the billing service or is this done electronically?
- If I bill paper claims, will the billing service make arrangements to pick them up?
- Does the billing service expect me to complete the claim form in its entirety or will they take the patient's claim information and complete the claim form for me?

Cost

Because cost options differ, it is important to look at the

amount you are typically charged per claim and your overall claims volumes so you understand the total cost to your practice. Questions, you may want to ask include:

- What is the cost per claim or percentage of total billed/allowed?
- If the computer is installed in my office, what is the rental or lease fee?

Insurance Companies

You may have to file claims to a variety of insurance companies and want to have them filed consistently whenever possible. You want to make sure the billing company has the capability to meet the claim requirements of these many different insurance companies. You should insure the billing service takes preventive measures to protect the confidentiality of both patient and provider data used in the submission of your claims. Questions you may want to ask include:

- Which insurance companies does this billing service currently submit bills to?
- Can the claims be submitted to these insurance companies in the manner I choose (i.e., paper or electronically)?
- Is there a difference in the charges between paper and electronic submission?

Completeness and Accuracy of Claims

Insuring that your claims are submitted as accurately and error-free as possible is a virtual guarantee of the quickest payment possible. However, use of a billing service does not relieve a provider of the accountability to insure the appropriateness of the services billed. Questions you may want to ask include:

- Will I be able to include specific types of records or documentation which are required by each insurance company or carrier for claims processing (crossover information, MSP documentation, CMN records)?
- What types of edits does the billing service have installed in their claim submission software? Does it include, at least, the Medicare Part B front end edits?

Note: Remember you are responsible for the accuracy of the information submitted to Medicare, regardless of how the claim was submitted, or who submitted the claim.

Timeliness

Not all billing services submit claims immediately upon receipt from their clients. Since some insurance carriers, including Medicare, make payment based on the date a claim was received, timely submission of claims is an important factor to consider, due to its impact on receipt of your payments. Questions you may want to ask include:

- How soon will the claim be filed to the insurance companies after being submitted to the billing service?
- Can a claim which is rejected due to front end edits or denied by an insurance company be re-filed electronically? If so, is there an additional charge for this service?

Record Retention

If you wish to stay informed during each step of the claims processing cycle, you may want to ask the following questions:

- Will I receive a claim summary showing all claims being submitted on my behalf?
- Will this confirmation show the total number of claims, total dollar amount and the date the claims were received by the carrier?

Availability of Other Electronic Services

You should also consider other electronic services or capabilities the billing service offers. You may want to ask the following question:

- Does the billing service have the capability to provide an Electronic Remittance Notification (ERN), Electronic Funds Transfer (EFT) or Electronic Claim Status (ECS)?

For further information regarding billing services or other electronic claim submission opportunities, contact your Medicare carrier.

Obtaining a Medicare Billing Number

In order to bill Medicare directly providers must first obtain a provider identification number (PIN). These numbers are issued for your use in billing Medicare for services rendered. Protect it like a credit card number. Ensure that others don't use this number to bill Medicare without your knowledge.

Authorizing Another Entity to Bill Medicare and Receive Payments on Your Behalf

Generally speaking, Medicare pays the provider that performed the service. In limited situations, however, Medicare may allow the performing provider to reassign Medicare payments to another entity. This is called "reassignment of benefits" and requires that various forms be completed, signed and returned to the carrier's provider enrollment department. A fully executed "reassignment of benefits" form is powerful because it allows another person or entity to bill Medicare on the provider's behalf and receive payments that otherwise would have been sent directly to the provider. Have you authorized someone else to bill and be paid by Medicare for services that you or your organization render? If so, you must be certain to ensure that such billings are appropriate and reflect services you actually performed.

Changing Your Billing Arrangements

Providers and suppliers may formally revoke the "reassignment" agreement by writing directly to the carrier's provider enrollment department. Failure to revoke outdated agreements allows that entity to continue to bill Medicare. Be certain that you have notified Medicare if your reassignment agreements are outdated or no longer valid.

Hiring Someone to Prepare Your Claims

As previously mentioned, some physicians and hospitals find it helpful to engage the services of a billing service or consultant to submit their Medicare claims. While such entities can provide valuable services, they should be engaged with caution. Delegating your entire claims preparation process does not protect you from being held responsible for the Medicare payments that are generated from the claims they file on your behalf. Before hiring a service or consultant, be certain to carefully check references and ensure that they:

- provide periodic reports of claims it has billed on your behalf and, if the billing service receives your Medicare payments, how much Medicare paid;
- protect your provider number and any other information used to act on your behalf;
- do not change procedure codes, diagnostic codes or other such information furnished by you or your organization without your knowledge and consent; and
- keep you informed of all correspondence received from Medicare.

Review these reports regularly to ensure consistency with your records. Also, keep complete administrative records for the claims that the billing service files on your behalf for seven years.

Hiring New Employees

Recent estimates for employee theft in the U.S. are approximately $50 billion each year. This fact combined with the provider's responsibility for the actions of their billing staff makes it critically important that your organization hires competent and ethical employees. Screen applicants carefully and develop internal controls within your organization in order to minimize risk. Install checks and balances in your organization's procedures to ensure the appropriateness of your interactions with Medicare. In addition, conduct periodic quality checks of sensitive processes such as the posting of account receivables.

Lost or Stolen Medicare Cards

Did you know that Medicare receives thousands of calls and letters from beneficiaries stating their Medicare cards have been lost or stolen and used by others?

Beneficiary impersonators are becoming more common as the cost of health care rises and people feel forced to resort to other measures to obtain necessary health care. As a result, HCFA is requesting that providers take action to avoid becoming victims.

One suggestion is to make a copy of each beneficiary's driver's license or some other form of valid identification and keep it on file. By doing so, office staff can quickly look at the picture on record to ensure that the patient receiving the service is actually the beneficiary named on the Medicare card.

Providers should beware of receiving false, fake, and fabricated Medicare cards as well as receiving false address and telephone information from their patients.

Remember it is the provider who is ultimately responsible for the verification of the identity of each patient receiving services from them. If services are rendered to a beneficiary impersonator, providers may be liable for an overpayment.

Offers of Free or Discounted Services

If a provider advertises services or a portion of services for free, the services cannot be billed to Medicare or any secondary policy.

Medicare requires that beneficiaries pay co-insurance on most services. Providing the service at no charge to the beneficiary, but billing Medicare (or both Medicare and the patient's secondary insurer) constitutes a routine waiver of co-insurance and is considered unlawful.

However, the waiver of co-insurance or deductibles would not be considered unlawful in instances when the beneficiary is unable to pay (e.g., indigent, poverty) and the information is documented in the patient records.

Documentation

If a service is not documented, one can argue it didn't happen. There are numerous situations that may warrant the need to present documentation for services rendered. Document the service as close to when the service was furnished as possible. Late entries arouse suspicion and increase the likelihood of inaccuracies.

Closing or Relocating a Practice

Medicare Part A Providers

Providers or suppliers wishing to obtain application information or to make changes to an existing application or file must contact the state agency responsible for licensure and certification.

Medicare Part B Providers

Inform your Medicare contractor if you decide to close or

move your practice. Your PIN should be updated in Medicare's system so that it cannot be used by another provider or entity. Please write to your carrier's provider enrollment department.

Staying Informed of Medicare Changes

Because there are constant changes in Medicare, it is important that mechanisms are in place at your organization to ensure that you remain abreast of those changes that affect your services. Explanations such as "I didn't know about that change," or "the staff is responsible for keeping up with billing changes" are not considered good excuses. Providers are not only responsible for the quality of the health care they or their organizations render, but also for knowing current Medicare billing requirements. Carefully review the provider bulletins and any other publications from Medicare.

Procedure Code Selection

Choose billing and revenue codes carefully and solely on that which is supported in the documentation. If this responsibility is delegated, be sure that staff understands the principles of coding. Perform periodic quality checks to ensure agreement with the codes being selected. Review coding manuals carefully to better ensure proper code selection.

Remember, providers are responsible for the claims prepared and submitted on their behalf.

Overpayment Issues

Medicare strives to ensure the accuracy of its payments, but occasionally mistakes occur. There are different methods of handling overpayments for Part A and Part B. If a Part A provider is erroneously paid for services not performed or is incorrectly paid for any other reason, overpayments should be resolved through the credit balance reports. If a Part B provider, return the money to Medicare immediately. Do not hold onto incorrect payments. In addition to interest and penalties that may be imposed on overpaid monies, the intentional withholding of an identified overpayment may be considered fraud.

Compliance Programs

In an effort to engage the health care community in combating fraud, waste, and abuse, the Department of Health and Human Services, Office of the Inspector General (OIG) issues guidance on compliance programs. In formulating the guidance, the OIG works closely with the Health Care Financing Administration (HCFA), the Department of Justice (DOJ), and various sectors of the health care industry. Based on their work, the OIG has identified seven fundamental elements to an effective compliance program:

- implementing written policies, procedures, and standards of conduct;
- designating a compliance officer and compliance committee;
- conducting effective training and education;
- developing effective lines of communication;
- enforcing standards through well-publicized disciplinary guidelines;
- conducting internal monitoring and auditing; and
- responding promptly to detected offenses and developing corrective action.

Although compliance programs are strictly voluntary, adopting one could be beneficial to a health care provider or any entity involved in the health care industry. Implementing a compliance program could assist them in establishing a culture within their organization that promotes prevention, detection, and resolution of instances that do not conform to Federal or State law, and Federal, State, or private payor health care program requirements, as well as ethical business conduct.

Those interested in implementing a compliance program based on the OIG's published guidance must understand that although there is basic procedural and structural guidance for designing and implementing a compliance program, the guidance in itself is NOT a compliance program. Rather, it is a set of guidelines for consideration in implementing such a program. The compliance program should effectively articulate and demonstrate the provider's or entity's commitment to legal and ethical conduct. Eventually, a compliance program should become part of the provider's or entity's routine operations. However, having a compliance program in place does not provide the health care provider or other organization with immunity from scrutiny and/or corrective action by the government or any Federal, State, or private payor health care program.

The documents issued by the OIG on compliance program guidance are published in the *Federal Register* and are also on the Internet at:

www.dhhs.gov/progorg/oig.

Special Notes for Physician Referrals

Providers sometimes need to refer patients for more specialized medical care or to receive certain diagnostic tests or supplies. In such cases, providers should do the following:

- Implement a process that helps ensure that only the services or tests ordered were rendered. (e.g., when reviewing the results of lab tests, note whether tests over and above those ordered were performed by the lab.)
- Always specify the reason the services are being ordered. If lab tests are ordered as part of a routine physical exam, include that fact with your referral. Do not empower the lab who files the Medicare claim to determine why the tests were needed.
- Never sign blank certification forms that are used by suppliers to justify Medicare payment for home oxygen, wheelchairs, hospital beds, prosthetic devices, etc.

Personally complete all medical information on such forms. Additionally, any demographic information, such as the patient's name and address should be fully completed before signing the form.

- Medical supplies and devices are sometimes aggressively marketed to beneficiaries with little regard for the beneficiary's medical condition. Examples of aggressively marketed items include TENS devices and power operated scooters. While these devices can be helpful for some beneficiaries, you should use extreme caution when prescribing them in light of the creative ways they are sometimes marketed.
- Where applicable, specify the quantity of medical supplies you believe are needed for your patients. An open-ended certification is like giving someone a blank check. Medicare has seen recent examples of suppliers providing supplies that were, in fact, certified by a physician but delivered in staggering quantities.
- Be suspicious if an entity offers you discounts, free services or cash to order services. If a deal sounds too good to be true, it probably is. You should contact the Department of Health and Human Services' Office of the Inspector General or a health care attorney if you think one of your current business arrangements places you at risk. The penalties for violating Medicare's anti-kickback laws can be severe. At the time of this writing, labs have paid the largest fines but physicians and hospitals have been prosecuted as well.
- Never certify the need for medical supplies for patients you have not seen and examined.

Special Issues For Providers Who Bill Clinical Laboratory Profiles

Some physicians who order clinical laboratory profiles from independent laboratories are supplied with check lists to order profiles or panels. While this may seem efficient, physicians must ensure that **each** service ordered is medically necessary, appropriate for the care and treatment of the patient, and clearly documented in the patient's medical record.

Some independent and/or hospital-based laboratories supply forms which allow physicians to order clinical laboratory profiles based on what may be most convenient for the laboratory's testing equipment as opposed to what the physician actually needs to establish a diagnosis. In actuality, this results in the submission of inappropriate claims to Medicare. To prevent this from occurring, physicians should not check the profile box if the laboratory does not give an option for the individual tests included in the profile, unless all tests in the profile are medically necessary. In these cases, providers should list each test that is to be performed. By listing the appropriate tests, only those tests that were medically appropriate and ordered by the physician may be billed and reimbursed.

Duplicate Claims May Be Considered Program Abuse

Approximately six percent of all claims filed to Medicare are denied as duplicate claims.

This represents an unnecessary waste of federal funds and is a target area for elimination by HCFA. Whenever possible, Medicare works with providers to eliminate duplicate claims.

Duplicate claims submission can occur from time to time; however, Medicare expects this rate to be less than one percent of all claims processed. Providers submitting the most duplicate claims will be identified and will be working with the Medicare contractor to learn about the various alternatives to duplicate filing.

Although determined on a case by case basis, Medicare may remove providers that continue to submit duplicate claims from the electronic billing network.

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CHAPTER 10
INQUIRIES, APPEALS, WAIVER OF LIABILITY AND OVERPAYMENTS

Introduction

Medicare Part B offers a number of different options to assist providers, suppliers, and others who work with the Medicare program. These options include service areas which can answer billing questions on medical topics. Medicare's Telecommunications/Customer Service area is in place exclusively to help you with most of your Medicare billing/coding issues. This is the area you will contact for most of your needs. Some of the services available from this area are outlined in this chapter.

Services Available By Telephone

Automated Response System (ARS)

At some Medicare carrier sites, an Automated Response System or (ARS) has been designed to provide the physician with information he/she would normally receive from a Customer Service Representative (CSR).

If your local Medicare carrier has an ARS, the types of information available on this ARS may include:

- claim status (complete information on assigned claims, limited status on non-assigned claims);
- number of pending and finalized claims;
- the date and check number of your most recent check;
- key explanations about why your claim was denied;
- the year-to-date dollar amount paid to you; and
- educational messages about hot topics.

Note: The local Medicare contractor can provide you with specific information regarding its ARS.

Other Benefits of Using An Automated Response System (ARS)

ARSs can usually be accessed 24 hours a day. One particular benefit of utilizing an ARS is there is usually no limit on the amount of time or the number of inquiries or information you can receive per telephone call. Using an ARS also can save time because the user has the ability to "speed dial" to move quickly through the menus of available information.

Services Available to Appeal Medicare Decisions - 1st Level

Who Can File For An Appeal?

Assigned Claims

Either the physician, the patient, or the patient's representative may request a review of an assigned claim. The request must usually be in writing, although most contractors offer a telephone review process. If a review of an assigned claim is requested, the response will be sent to the requestor, unless we are advised to send the response to another party.

Non-assigned Claims

Review requests for non-assigned claims are handled differently. When the claim is non-assigned, a physician may request a review only if the services were denied or reduced, based on medical necessity guidelines, and the physician is liable for the denial or reduction. Additionally, the physician may request a review of a non-assigned claim if the beneficiary gives written authorization. This written authorization must be included with the review request.

What Can I Do If I Disagree With Medicare's Denial?

Certain types of claim denials can generally be handled by resubmitting the claim with the correct information. Examples of denials for which a claim can be resubmitted include: the claim is denied due to insufficient information; the "return as unprocessable" claims, or the diagnosis is not coded to the highest level of specificity.

Certain types of claim denials can generally be handled by a telephone review request. The local carrier will provide the information about the telephone review process.

Other types of claim denials can only be handled through a written review request. Examples of denials for which a written review must be requested include: utilization limit denials, and services denied because the diagnosis did not warrant the procedure and the correct diagnosis was indicated on the claim form. When requesting a review request, it may be necessary to include medical documentation which justifies the procedure. The local carrier will provide the information about what type of information should be included with a review request.

How Will I Be Notified of The Review Decision?

Once the review request is completed, a written response will be sent. The response varies depending upon the action taken:

- If the original decision on the claim is upheld, a detailed letter will be sent explaining why additional payment cannot be allowed.

- If it is determined that the original decision on the claim can be changed and payment is due, a new remittance notice and a check will be issued.

- If the original decision on the claim is changed, but no further payment is due, a detailed letter will be sent explaining the reasons why no payment is forthcoming and a new remittance notice indicating the revised decision is issued.

- If it is determined that a portion of the claim can be allowed, a check will be issued for the service(s) allowed, with a corrected remittance notice. A separate detailed letter will be sent explaining the adjustment and explaining why additional payment cannot be allowed on the other service(s).

Review letters explain the rights of a Medicare Part B hearing, should one be requested.

What Are My Next Steps After A Review?

If after having a review you are still dissatisfied, and the amount in controversy is $100 or more, a hearing may be requested. This means the difference between the billed amount and the Medicare allowed amount, less any outstanding deductible, must be $100 or more. Claims which have been previously reviewed or reviews that have been reopened to meet the $100 requirement may be combined.

Fair Hearing- 2nd Level

Types of Fair Hearings

There are three types of hearings:

- **On-The-Record (OTR) hearing**

  An On-The-Record hearing is a type of hearing in which the hearing officer prepares and sends to the provider or their representative a decision based solely on the facts in the record, which includes all evidence submitted with the provider's written request for a hearing.

- **Telephone hearing**

  The telephone hearing offers a convenient and less costly alternative to the "in-person" hearing since the need to appear is eliminated. Oral testimony and oral challenges may be conducted via the telephone.

- **In-person hearing**

  Providers and/or representatives are given the opportunity to present both oral testimony (as with telephone hearings) and written evidence supporting their claim and refuting or challenging the information the carrier used to deny their claim.

Regardless of the type of hearing requested (telephone, in-person, or a decision based on the record), the hearing officer will perform an On-The-Record hearing and notify the claimant, in writing, of the determination. The written response will include the date and time of either the in-person or telephone hearing and an option to notify Medicare if the provider wishes to cancel the hearing based on the results of the On-The-Record decision. An On-The-Record decision will not be performed prior to either a telephone or in-person hearing if the following criteria are met: the On-The-Record would significantly delay the hearing; the issue is medical necessity; or oral testimony and cross-examination is necessary to clarify the facts. If an On-The-Record hearing is not performed, the provider will be notified of the date and time of the telephone or in-person hearing.

Hearings are conducted by a hearing officer appointed by Medicare. The hearing officer's role is to determine whether or not the carrier has followed Medicare guidelines in making the determination in question.

How Do I File A Request For A Hearing?

Submit the request in writing, clearly explaining why you are not satisfied with the review determination, and indicate the type of hearing being requested. Send the request, a copy of the review notice and any additional evidence you may to wish to include, to the address indicated on the remittance notice.

How Long Do I Have To File A Hearing Request?

A hearing request must be filed within six (6) months from the date on the previous notification (review letter or corrected remittance notice). Requests filed after this time period will not be considered.

Administrative Law Judge - 3rd Level

The decision made by the hearing officer, in many cases, is final and binding. If at least $500 remains in controversy following the hearing officer's decision, further consideration may be made by an Administrative Law Judge (ALJ). The hearing determination will include instructions for obtaining an ALJ hearing. The request must be made within 60 days of receipt of the hearing determination. The ALJ will advise you of hearing preparation procedures.

Judicial Review in Federal Court - 4th Level

If at least $1,000 remains in controversy following the ALJ's decision, you are entitled to judicial review before a Federal district court judge.

Waiver of Liability

Waiver of Liability - The Law

Sections 1842(1) and 1879 of the Social Security Act were

intended to protect the patient from financial liability when payment for a service/item he/she has received is denied or reduced as "not reasonable and necessary" under Medicare guidelines. This protection is known as "waiver of liability". Under this provision, the patient may not be required to pay the provider for the service if certain conditions are met.

When Is A Service Not Considered Reasonable And Necessary?

Section 1862(a)(1) of the Medicare law prohibits payment for services/items that are not medically reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. A service/item may be considered not reasonable and necessary for the following reasons (this is not an inclusive list):

- the service/item is not covered based on the diagnosis/condition of the patient;
- the frequency/duration of the service was provided beyond the accepted standards of medical practice;
- the medical documentation did not justify the medical necessity of the service/item; and/or
- the service was not rendered in a certified facility.

The physician is considered to know or will be expected to know that a service/item may be denied or reduced payment as not medically reasonable and necessary when:

- the specific medical necessity requirements were published by the contractor; or
- the physician has received a previous review, waiver of liability or hearing decision or other notice for the service/item which informs him/her of medical necessity requirements; or
- the physician has received a denial or reduction of payment on the same or similar service/item; or
- the physician can reasonably be expected to know the requirement based on standard medical practice within the community.

Note: The remittance notice which shows the denial/reduction of payment, serves as formal notice of the medical necessity requirements.

When Do I Need To Provide An Acceptable Advance Notice to A Patient?

In cases where the physician believes that the service/item may not be covered as medically reasonable and necessary, an acceptable advance notice of Medicare's possible denial of payment must be given to the patient if the physician does not want to accept financial responsibility for the service/item. This notification serves as protection for both the physician and the patient and requires the following:

Patient: The patient should be notified **before** the service is rendered that payment may be denied or reduced. The patient can then decide if he/she wants the service rendered and is willing to pay for it.

Physician: If the physician notifies the patient in advance that payment for the service may be denied or reduced, then the physician is not held financially liable for his/her services; he/she may seek payment from the patient.

Does The Advance Notice Have Any Specific Criteria?

An acceptable advance notice of the denial or reduction of payment must meet the following criteria:

- the notice must be given in writing, in advance of providing the service/item;
- the notice must include the patient's name, date and description of service/item, and reason(s) why the service/item may not be considered medically reasonable or necessary and therefore may be denied or a reduction in payment could occur; and
- the notice must be signed and dated by the patient each time a service will be rendered, indicating that the patient assumes financial liability for the service/item if payment is denied or reduced for the reasons indicated on the advance notice.

Claim Filing Requirements

Assigned or non-assigned claims billed to Medicare Part B should contain modifier GA next to each applicable service, when you wish to note that proper advance notice has been given and signed by the patient. While the advance notice form does not need to be submitted with the claim, you **must** maintain a copy of the signed document with the patient's medical records.

Are There Any Physician Appeal Rights?

In cases where payment for a service is denied or reduced as not medically reasonable and necessary and the patient is found not to be liable for payment (i.e., advance notice was not given), you are required to refund (within 30 days from the date the claim was processed) any monies collected from the patient for the service.

You may, however, request a review on either assigned or non-assigned claims in these instances.

For both assigned and non-assigned claims, if the original claim determination is upheld and it is found that the physician knew, or could have been expected to know that payment for the service may be denied or reduced, the physician is held liable and must refund (within 30 days

from the date of the review decision) any monies collected from the patient for the service.

Assigned claims: If the original claim determination is upheld but it is found that the physician could not have been expected to know that payment for the service may be denied or reduced, program payment is made to the physician.

Non-assigned claims: If the original claim determination is upheld but it is found that you could not have been expected to know that payment for the service may be denied or reduced, you are notified that you may collect payment from the patient. A letter is then sent to the patient indicating that he/she is responsible for payment.

What Happens If I Do Not Refund Monies Due?

In cases where the patient is not responsible for the payment of a service, the physician must refund any monies previously collected from the patient. If the physician does not refund the monies within the specified periods, the following steps may occur:

- **Assigned Claims:** The patient may submit a request to Medicare for indemnification from payment. A letter is then sent to the physician which notifies him/her that a refund must be made within 15 days. The refund must be for the amount actually paid to the physician including any amounts that were applied to the deductible or coinsurance.

- **Non-Assigned Claims:** The patient may notify Medicare Part B that you did not refund the amount due. Medicare Part B then contacts the physician to explain that a refund is due to the patient. If a refund is not made within 15 days, the physician may be subject to civil monetary penalties and sanctions.

For either claim, if a refund is not made within 15 days, payment will be made to the patient and an overpayment request will be sent to the physician for the amount actually paid to physician for the service(s) at issue.

Is Advance Notice Required For Services Rendered on The Referral Or Order of Another Physician?

Despite the fact that some physicians may have a limited degree of contact with patients for services provided on the referral or order of another physician, they are expected to be aware of the medical necessity requirements for the services they provide (if they have been made available). In most cases, the availability of the medical necessity requirements indicates that the physician knew, or should have known, that payment for the item/service may be denied or reduced as not medically necessary.

If, after considering the medical necessity requirements for a service/item, you believe there is a likelihood that payment may be denied or reduced as not reasonable or medically necessary, an acceptable advance notice of the denial/reduction of payment should be provided to the patient.

For services which are ordered by another physician (e.g., diagnostic tests), the advance notice may be provided by the physician who ordered the services. If you rendered the services you will not be held liable for the services if payment were denied/reduced. However, you may be required to produce a copy of the advance notice if proof of the notice is required. In addition, if the advance notice is considered unacceptable, you will be financially liable for the services.

For services which are rendered on the referral of another physician, the physician who actually renders the service is in the best position to determine the likelihood of the denial/reduction of payment and, therefore, is responsible for providing an acceptable advance notice to the patient. An advance notice from the referring physician, in this instance, would not protect you from financial liability if payment were denied or reduced.

Overpayments

This section explains what should be done when the physician has been overpaid by Medicare.

What Is An Overpayment?

An overpayment occurs when Medicare pays more than what should have been paid. This sometimes happens because of the following:

- duplicate processing of the same service;

- payment to the incorrect payee;

- payment for non-covered or medically unnecessary services; and

- payment made on a primary basis when Medicare should have paid on a secondary basis.

Keep in mind that when Medicare makes payment to the incorrect payee, this information is communicated like all other payments, to the Internal Revenue Service (IRS). Therefore, if the payee is incorrect, Medicare must request the monies back and reprocess the services to the correct party.

What Are My Responsibilities If I Am Overpaid?

If Medicare over pays in error, refund the overpaid amount as soon as possible — do not wait for Medicare to send a letter asking for it. Contact your local carrier to obtain the name and address of the department to whom you should mail the refund. When you mail the refund, make sure you include the following information:

- the provider number (and that of the provider who should

be paid if applicable);

- the Medicare number of the patient(s) in question, the date of service and amount overpaid;
- a brief description of why the refund is being made;
- a copy of the remittance notice highlighting the claim(s) at issue; and
- a check for the amount overpaid.

What Does Medicare Do If They Find The Overpayment Before I Do?

Medicare will send a letter listing the services at issue, why the overpayment occurred and the amount being requested. The physician will then have 30 days from the date on this letter to mail a refund to the address listed in the letter. If the refund is not received within **thirty** days from the date of the first letter, a second letter will be sent and the balance due will be satisfied by withholding future claim payments until satisfied (otherwise known as offset).

If I Am Put on "Offset" Due to A Large (Or Multiple Claim) Overpayment, How Can I Reconcile My Records?

When Medicare notifies the physician of an overpayment and multiple claims are involved, the letter will outline all claims which were overpaid.

What If I Disagree With The Overpayment?

If you disagree with the overpayment, you have a right to appeal the decision. However, keep in mind that submitting an appeal, does not in itself prevent offset. Be sure to include an explanation of why you feel the overpayment is not correct. This now becomes a review with the standard review guidelines being applicable.

What About Interest?

Medicare is required to collect interest on overpayments not satisfied within 30 days from the date of the refund letter.

What If I Have Questions?

If you have questions about the overpayment process or what should be done in cases where an overpayment might have been made, call the provider customer service area.

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CHAPTER 11
MATERIALS/PHONE NUMBERS/ADDRESSES

Materials

There are several reference materials that have been mentioned throughout this book that will help when coding and filing claims to the Medicare carrier.

What Books Can I Use To Code My Procedures?

All Medicare carriers update their Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS) codes annually. Procedure code changes are updated annually effective date is January 1 with a 90 day grace period through March 30. Diagnosis codes are updated annually effective October 1st.

Level I CPT codes

- All Numeric
- Assigned by the American Medical Association (AMA)

Level II HCFA codes

- Alphanumeric (Procedure codes begin with alphabet in the A-V series)
- Assigned by HCFA, Blue Cross and Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA)

Level III Locally Assigned Carrier Codes

- Alphanumeric (Procedure codes begin with alphabet in the W-Z series)
- Assigned by the carrier and represent procedures not identified by a Level I or Level II procedure code.

Interim/Temporary Use

- Alphanumeric (Procedure codes begin with Q)
- Assigned by HCFA

How Can I Purchase These Books?

Level I - CPT Book

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19904
1-800-621-8335

Level II - HCPCS Book

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402
1-202-512-1800

Level III and Interim codes are published by each carrier.

ICD-9-CM Diagnosis Coding Book

- Volumes 1, 2 and 3 can be obtained by visiting your local medical book store or writing to several sources such as:
- St Anthony's Publishing Softbound ICD-9-CM Code Book for Physician Payment:
  11410 Isaac Newton Square
  Reston, VA 22090
  or call: 1-800-632-0123 or (703) 904-3900

Medicare Part B Publications

All carriers are required to publish, on a regular basis, Medicare changes, local policy and fee schedule updates to their providers.

Free Medicare Education!!!

HCFA is now offering free Medicare education for all Medicare providers and their staff. There is no need to wait for a seminar when free training is offered at your own pace and convenience. This training is called Computer Based Training (CBT). Please refer to the Appendix for more information regarding this offer.

Courses are also being offered utilizing satellite technology.

For a list of available topics, times and host site locations, access the "Learning Resources" section of HCFA's web site. The address is:
http:/www.hcfa.gov/learning/default.htm.

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CHAPTER 12
TERMS YOU SHOULD KNOW

Introduction

The following is a list of terms which may be helpful as you learn about the many areas, functions, and day-to-day requirements of the Medicare program.

A

Aberrancy - Medical services that deviate from what is considered normal or typical when compared to the national average.

Abuse - Any incident or practice of a provider, physician, or supplier which, although not usually considered fraudulent, is inconsistent with accepted and sound medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to the Medicare program, improper reimbursement, or program reimbursement for services that fail to meet professionally recognized standards of care or, in some cases, may be medically unnecessary.

Adjudication - The process of deciding whether to allow or deny a claim based upon the information submitted and the eligibility of the recipient.

Adjustment - Additional payment or correction of records on a previously processed claim.

Admission - Entry to a hospital or other health care institution as an inpatient.

Ambulatory Surgical Center (ASC) - A facility that operates exclusively for the purpose of providing outpatient surgery services to patients.

Appeal Request - Written statements that convey an explicit or implicit request for a review of the initial determination, or conveys dissatisfaction with the most recent determination made related to a claim.

Approved Charge - The fee schedule amount that Medicare has determined allowable for payment.

Assignment - A process in which a Medicare beneficiary agrees to have Medicare's share of the cost of a service paid directly to the provider. The provider agrees to accept the Medicare approved charges as payment in full.

B

Balance Billing - The difference between the billed amount and the amount approved by Medicare.

Balanced Budget Act - The Balanced Budget Act of 1997 was signed into law on August 5, 1997, by President Clinton. The law makes numerous changes to the various titles of the Social Security Act and includes several anti-fraud and abuse provisions and improvements in protecting program integrity.

Beneficiary - A person entitled to Medicare benefits under the Social Security Administration.

Billing Service - A company that generally handles claim filing to various insurance companies for provider and/or supplier offices. There is a fee associated with the service.

Blue Cross Association (BCA) - A non-profit corporation representing the Blue Cross and Blue Shield plans on a national level as a coordinating agency in marketing, government relations and other system wide initiatives; owns the Blue Cross Blue Shield mark and sets approval standards.

C

Carrier - An organization that contracts with HCFA to provide claims processing and payment for Medicare Part B services.

Claim - Paper forms or the electronic submission of information, for payment of medical services and supplies provided to Medicare beneficiaries.

Clearinghouse - These organizations usually operate on a national scale. Commercial claims as well as Medicare Part B claims are received by the clearinghouse host computer from provider/supplier locations across the country. The claims are separated by the clearinghouse and then forwarded to each respective carrier. Some clearinghouse organizations charge a "dial-in" fee in addition to a per-claim charge.

Clinical Laboratory Improvement Amendments (CLIA) - Regulations which set quality and performance standards for all laboratory testing. All providers of laboratory services are required to be certified under the CLIA program.

Coinsurance - A type of cost-sharing where the insured party and insurer share payment of the allowed charge for covered services in a specified ratio, which occurs after payment of the deductible is made by the insured.

Community Mental Health Center (CMHC) - A facility that provides outpatient mental health services to individuals residing within a specific geographic area.

Contractor - A contractor for Medicare purposes is defined as a Fiscal Intermediary (FI), Carrier, Durable Medical Equipment Regional Carrier (DMERC), or Regional Home Health Intermediary (RHHI).

Covered Services - Services rendered to Medicare or Medicaid patients that are reimbursable by the program to the provider.

CPT/ Current Procedural Terminology - The coding system for healthcare services developed by the CPT Editorial Panel of the AMA.

D

Date of Service - The date the services were actually performed.

Deductible - Amount that must be paid by an insured person before an insurance plan pays any portion of the associated costs.

Diagnosis - Identifies the condition, cause or disease of the patient.

Diagnostic - Procedures used to discover the nature and underlying cause of illness.

Durable Medical Equipment (DME) - DME is equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home.

Durable Medical Equipment Regional Contractor (DMERC) - An organization that contracts with HCFA to provide Medicare claims processing and payment for supplies, DME, prosthetics and orthotics.

E

Electronic Funds Transfer (EFT) - EFT provides the capability of electronically sending Medicare payments directly to the physician's financial institution.

Electronic Media Claims (EMC) - A communications process where claims are sent electronically from a computer to a claims processing center. EMC allows you to bypass several steps of the paper claims process by eliminating the need for mail room processing and manual data entry by claims examiners.

Electronic Remittance Notice (ERN) - A physician, who sends claims electronically from a computer to a claims processing center, can receive paid and/or denied claims information electronically from Medicare. The ERN is equivalent to the Medicare Remittance Notice (MRN) form.

Entitlement - Refers to a Medicare beneficiary who can receive benefits under the Medicare program (e.g., the date of entitlement begins at age 65 for most beneficiaries).

Exclusions - A provision in the law stating situations or conditions under which coverage is not afforded by the subscribers' contract. Or, can describe penalty imposed by DHHS, OIG on providers prohibiting them from billing Medicare or other government programs.

Experimental or Investigative - Any treatment, procedure, equipment, drugs, drug usage, or devices not approved by the FDA.

Explanation of Medicare Benefits (EOMB) - A form sent to a Medicare beneficiary after a claim is processed indicating how Medicare processed the claim.

F

Fee Schedule - A list of certain services and payable amounts indicating the maximum Medicare payment for the service (e.g., clinical lab and durable medical equipment).

Fiscal Intermediary (FI) - An insurance company that contracts with HCFA to process Medicare Part A claims (hospital insurance).

Focused Medical Review (FMR) - A two-fold educational process designed to insure both appropriateness of medical care and the carrier's medical policies and review guidelines are consistent with the standards of medical practice.

Fraud - Intentional deception or misrepresentation which an individual or entity makes, knowing it to be false and that the deception could result in some unauthorized benefit.

G

Global Fee - As it pertains to diagnostic services, it represents the combined technical (equipment charges) and professional (physician charges) billings or payments.

H

Health Care Financing Administration (HCFA) - The part of the Department of Health and Human Services that administers and oversees the Medicare program and a portion of the State Medicaid program.

Health Care Financing Administration Common Procedure Coding System (HCPCS) - A Medicare coding

system for describing services based on the American Medical Association's (AMA) CPT descriptors, but supplemented with additional codes. It includes three levels of codes as well as modifiers. This coding system is designed to incorporate all medical services, to be universal, and to be consistent with the AMA's CPT coding system.

Health Insurance Claim (HIC) Number - Refers to the number issued by the Social Security Administration to a person covered under the Medicare program.

Health Insurance Portability and Accountability Act (HIPPA) - The Health Insurance Portability and Accountability Act of 1996 (HIPPA), (also known as the Kennedy-Kassenbaum bill), was signed by President Clinton on August 21, 1996. Among other provisions, the Act is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. The Act imposes significant changes to fraud and abuse controls.

Health Maintenance Organization (HMO) - A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers.

Health Professional Shortage Area (HPSA) - Medically under-served areas where physicians are entitled to a ten percent bonus payment for all professional physician services (e.g., those services subject to the Medicare physician fee schedule).

Hearing - An informal hearing held by a hearing officer to determine if the carrier's action on a claim complied with Medicare law. A hearing may not be held unless the amount in controversy (minus deductible and coinsurance) is at least $100. More than one claim may be used to satisfy the $100 requirement. A hearing must be requested with six months of an informal review.

Home Health Agency - An approved association or organization where a Medicare patient who is home bound receives skilled nursing and/or therapeutic care in the home.

Hospice - A hospice is a facility which provides palliative care for a terminally ill person. In order for a beneficiary to be eligible for enrollment in a certified hospice program, his/her life expectancy has to be six months or less. When a beneficiary elects hospice coverage, all services except the professional services of an attending physician related to the treatment and management of the terminal illness, are processed by Medicare Part A.

Hospital - Institution with organized medical staff, with permanent facilities that include inpatient beds and with medical services, including physician services and continuous nursing services.

Hospital Based Physician - An MD or DO under contract or arrangement to provide service in a hospital setting, salaried or unsalaried, who renders treatment or services in the hospital environment.

I

Inpatient - One who occupies a regular hospital or other institutional bed while receiving care, including room, board and general nursing.

International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) - A national coding method to enable providers to effectively document the medical condition, symptom or complaint which is the basis for rendering a specific service(s). This coding system consists of three to five digit numeric or alphanumeric codes for reporting purposes.

Inquiry - All oral and written contacts which do not request a re-examination of or state a dissatisfaction with the previous claim determination. These contacts usually pertain to claim status or general information, such as deductible, entitlement, etc.

L

Licensed Physician - A licensed physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.); a doctor of dental surgery or dental medicine, acting within the scope of his/her license; a doctor of podiatry with respect to functions which he/she is legally authorized to perform; a doctor of optometry with respect to the provision of items or services which he/she is legally authorized to perform; or a chiropractor with respect to treatment by means of manipulation of the spine.

Lifetime Reserve Days - The non-renewable, one-time bank of 60 days that a Medicare patient is given that can be used when the covered days of a spell of illness are exhausted.

Limiting Charge - The maximum amount that a nonparticipating physician and certain suppliers are permitted to charge a Medicare beneficiary for a service; in effect, a limit on balance billing. Starting in 1993, the limiting charge was set at 115% of the Medicare allowed charge.

Local Medical Review - An educational process designed to insure appropriateness of the carrier's medical policies, medical care, and review guidelines are consistent with the standards of medical practice.

M

Medicaid - A federal/state program, established by Title XIX of the Social Security Act. A program of Federal matching dollars to the states to provide health insurance for the poor and medically indigent.

Medical Review - A process that includes the application of medical criteria, knowledge, or judgment to insure that payments are made for items/services that are covered, appropriate, and medically necessary.

Medically Necessary Services - Those services determined by Medicare to be:

- consistent with symptoms or diagnosis and treatment of the insured's condition, disease, ailment or injury;
- appropriate with regard to standards of good medical practice;
- provided not primarily for the convenience of the insured, the hospital or the physician; and
- the most appropriate level of service that can be safely provided.

Medicare Part A - Part of the Medicare program which reimburses a portion of facility charges for beneficiaries who receive services from certain institutions, such as hospital (inpatient and outpatient), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), and end-stage renal dialysis (ESRD) facilities.

Medicare Part B - Part of the Medicare program which reimburses covered physician and supplier services rendered in various places, such as a doctor's office, outpatient hospital, patient's home, nursing home, etc.

Medicare Remittance Notice (MRN) - A summarized statement for providers which includes payment information for one or more beneficiaries.

Medicare Summary Notice (MSN) - A statement sent to a Medicare beneficiary which indicates how Medicare processed the claim.

Medigap Policy - Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance, and balance bills, as well as payment for services not covered by Medicare.

N

National Provider Identifier (NPI) - A unique number assigned to each Medicare provider in the future.

Non-Assigned Claim - A claim potentially payable directly to the Medicare beneficiary.

Non-Participating Provider - A physician who does not sign a participation agreement and, therefore, is not obligated to accept assignment on Medicare claims.

Non-Physician Practitioner - A health care provider who meets state licensing requirements to provide specific medical services. Medicare payment may be made for the professional services of many non-physician practitioners. These non-physician practitioners include: certified registered nurse anesthetists/anesthesia assistants, physician assistants, clinical nurse specialists, nurse practitioners, nurse midwives, physical therapists, occupational therapists, clinical psychologists, licensed clinical social workers, and audiologists.

O

Office of Inspector General (OIG) - The OIG is the branch of the Federal government responsible for enforcing and prosecuting providers who are convicted of a Medicare fraud or abuse offense.

Optical Character Recognition (OCR) - An automated scanning system that reads the information submitted on claim forms. With OCR, claims processing is faster and more accurate than manual processing because of the need for little or no manual intervention.

Outpatient - A member receiving hospital care but not occupying a regular hospital bed or receiving room, board and general nursing care.

Overpayment - An overpayment occurs when Medicare has paid a physician, provider or facility more money than what should have been paid.

P

Participating Physician - A physician who signs a participation agreement/contract to accept assignment on all claims submitted to Medicare for processing.

Payment Floor - The time frame established for carrier payment of Medicare Part B claims. Electronically submitted claims will be paid 14 days after the date of receipt, while paper claims will be paid 30 days after the date of receipt.

Peer Review - Evaluation of a health care practitioner's professional services by other practitioners of the same profession.

Place of Service (POS) - Where a service is performed, e.g., hospital inpatient, hospital outpatient, doctor's office, etc.

Premium - Part A - The amount paid by an individual who

is 65 years of age or older to obtain Medicare Part A coverage when they do not meet the requirements for premium-free Part A coverage. Part B - The amount paid by a Medicare Part A beneficiary to obtain coverage for Part B services.

Provider - A generic term for any person (e.g., a physician) or entity (e.g., a home health agency, a skilled nursing facility, a hospital, etc.) approved to provide/give care to Medicare beneficiaries and to receive payment from Medicare.

Purchased Diagnostic Tests - A test (e.g., EKG, X-ray, ultrasound, etc.) purchased from an outside supplier for which a physician bills, but does not personally perform or supervise.

Q

Query - A record transmitted to the Social Security Administration (SSA) to receive entitlement information on an individual beneficiary (or subscriber).

Qui Tam - This is a provision in the law which allows persons having knowledge of a false claim against the government to bring an action in a Federal district court for themselves on behalf of the United States government.

R

Relative Value - One of the several major components utilized in the calculation of the Medicare Fee Schedule (MFS). There is a HCFA established RVU for each of the following three components: work, overhead and malpractice.

Reopening - A reevaluation of a claim determination. A reopening is not an appeal right. It is a discretionary action in response to the identification of an error, fraud or the submission of new material and information not available at the time of the last adjudication.

Review - The first formal level of appeal, following a denial of a claim.

S

Skilled Nursing Facility (SNF) - An institution or a distinct part of an institution, which has a transfer agreement with one or more hospitals and is primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Social Security Administration (SSA) - The branch of the Department of Health and Human Services that operates the various programs funded under the Social Security Act. It also determines when an individual becomes eligible for Medicare benefits.

Subrogation - A plan's right to the recovery of money paid when it is found another party is legally responsible for payment of expenses.

T

Title XIX - Medicaid program.

Title XVIII - Medicare program.

U

Unique Physician Identification Number (UPIN) - A unique number assigned to each Medicare physician, for identification purposes, regardless of the number of associations in which they may practice.

Utilization - The percentage of usage by Medicare patients of a given facility's, or health care provider's, services.

V

Vendor - A vendor provides hardware, software and/or ongoing support services for a fixed purchase price or a lease-to-own option for providers to file electronically to Medicare.

W

Waiver of Liability - A provision designed to protect the beneficiary from liability under certain conditions when the services furnished are found to be not reasonable and necessary.

NOTES

NOTES

ACKNOWLEDGMENTS

Published Resource Materials:

Federal Register, Volume 63, No. 211, Office of the Federal Register, National Archives and Records Administration, United States Government Printing Office, Monday, November 2, 1998

HHS Announces Medicare Deductible and Premium for 1999, Health Care Financing Administration Press Office - hcfa.gov, October 16, 1998

International Classification of Diseases 9th Revision Clinical Modification ICD-9-CM 1999-2000, Volumes 1 & 2, American Medical Association, October 1998–September 1999

Medicare B Update!, Published by - First Coast Service Options, Inc., Medicare Part B of Florida

Medicare Carriers Manual - Part III, U.S. Department of Health and Human Services, Health Care Financing Administration

Medicare Coverage Issues Manual, U.S. Department of Health and Human Services, Health Care Financing Administration

Medicare Part A Intermediary Manual - U.S. Department of Health and Human Services, Health Care Financing Administration

Current Procedural Terminology CPT '99, American Medical Association, October, 1998

Your Medicare Desk Reference 1998, U.S. Department of Health and Human Services, Health Care Financing Administration, U.S. Government Printing Office, 1998

Brief Summaries of Medicare and Medicaid, Health Care Financing Administration, June 1998

APPENDIX -FORMS/INFORMATION

This sections contains common forms and marketing materials utilized in the Medicare program.

Forms/Information:

HCFA-1500 (12/90) Medicare Part B Claim Filing Form I

HCFA-1450 (UB-92) Medicare Part A Claim Filing Form V

HCFA-460 Medicare Participating Physician or Supplier Agreement IX

Written Advanced Notice XIII

HCFA Recognized Physician Specialties XVII

Place of Service (POS) Definitions XXI

Marketing Information:

Medicare Web Site Information XXV

HCFA-1500 (12 / 90)

Medicare Part B Claim Filing Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

HCFA-1450 (UB-92)
Medicare Part A Claim Filing Form

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
	a	.		.		.	a
	b	.		.		.	b
	c	.		.		.	c
	d	.		.		.	d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						.	.		1
2						.	.		2
3						.	.		3
4						.	.		4
5						.	.		5
6						.	.		6
7						.	.		7
8						.	.		8
9						.	.		9
10						.	.		10
11						.	.		11
12						.	.		12
13						.	.		13
14						.	.		14
15						.	.		15
16						.	.		16
17						.	.		17
18						.	.		18
19						.	.		19
20						.	.		20
21						.	.		21
22						.	.		22
23						.	.		23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A					.	.		A
B					.	.		B
C					.	.		C
57		**DUE FROM PATIENT ▶**			.	.		

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		

	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	
	C		D		E		A	a
								b
							OTHER PHYS. ID	a
							B	b

a	84 REMARKS	85 PROVIDER REPRESENTATIVE X	86 DATE
b			
c			
d			

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

HCFA-460

Medicare Participating Physician/Supplier Fact Sheet and Agreement

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant* (Please Type or Print)	Physician or Supplier Identification code(s)*
_____	_____

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.**
2. **Effective Date - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective on January 1.**
3. **Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:**

   a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

   b. The Health Care Financing Administration may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Health Care Financing Administration will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

_____	_____	_____	_____
Signature of participant (or authorized representative of participating organization)	**Title (If signer is authorized representative of organization)**	**Date**	**Office phone number (including area code)**

Received by _____
(name of carrier)

Effective date _____

Initials of Carrier official _____

***List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.**

HCFA-460

Written Advanced Notice

Provider Notice to Beneficiary Regarding Service(s) That Are Likely to be Denied Payment by Medicare Part B as "Not Reasonable and Necessary"

Beneficiary's Name: **Health Insurance Claim Number:**

_____ _____

Physician/Supplier Notice to Beneficiary:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare Program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for the following service(s) for the reason(s) noted below:

Date and Description of Service/Reason for Medicare's Denial of Payment:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Beneficiary's Acknowledgment and Agreement to Pay:

I have been notified by my physician/supplier that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denied payment, I agree to be personally and fully responsible for payment to my physician/supplier.

_____ _____

Beneficiary's Signature **Date**

HCFA Recognized Physician Specialties

HCFA Recognized Provider Specialties

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
10 Gastroenterology
11 Internal Medicine
12 Osteopathic Manipulative Therapy
13 Neurology
14 Neurosurgery
16 Obstetrics/Gynecology
18 Ophthalmology
19 Oral Surgery (Dentists only)
20 Orthopedic Surgery
22 Pathology
24 Plastic & Reconstructive Surgery
25 Physical Medicine and Rehabilitation
26 Psychiatry
28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease
30 Diagnostic Radiology
33 Thoracic Surgery
34 Urology
35 Chiropractor
36 Nuclear Medicine
37 Pediatric Medicine
38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 CRNA Anesthesia Assistant
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology
47 Independent Diagnostic Testing Facilities (IDTF)
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner (ARNP)
51 Medical Supply Co. W/Certified Orthotist
52 Medical Supply Co. W/Certified Prosthetist
53 Medical Supply Co. W/Certified Prosthetist-Orthotist
54 Medical Supply Co. not included in Specialty **51-53**
55 Individual Certified Orthotist
56 Individual Certified Prosthetist
57 Individual Certified Orthotist- Prosthetist
58 Individual not included in **55-57**
59 Ambulance Service Supplier (Private Ambulance Co., Funeral
61 Voluntary Health or Charitable Agencies
62 Psychologist (Ph.D.) Billing Independently
63 Portable X-Ray Supplier
64 Audiologist (Billing Independently)
65 Physical Therapist (Independent. Practice)
66 Rheumatology
67 Occupational Therapist (Independ. Practice)
68 Clinical Psychologist
69 Clinical Laboratory (Billing Independ.)
70 Multi-Specialty Clinic or Group Practice
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care
82 Hematology
83 Hematology/Oncology
84 Preventive Medicine
85 Maxillofacial Surgery
86 Neuropsychiatry
87 All Other (Drug & Dept. Store, etc.)
88 Unknown Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
95 Independent Diagnostic Testing Facility
97 Physician Assistant (PA)
98 Gynecological/Oncology
99 Unknown Physician Specialty

Place of Service (POS) Definitions

Medicare Part B Two Digit Place of Service Indicators

11 Office - Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

12 Patient's Home - Location, other than a hospital or other facility, where the patient receives care in a private residence.

21 Inpatient Hospital - A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital - A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room - Hospital - A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center - A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center - A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of new born infants.

26 Military Treatment Facility - A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31 Skilled Nursing Facility - A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility - A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility - A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice - A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

41 Ambulance-Land - A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 Ambulance Air or Water - An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

50 Federally Qualified Health Center - A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization - A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center (CMHC) - A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54 Intermediate Care Facility/Mentally Retarded - A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility - A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents

who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center - A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

60 Mass Immunization Center - A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting. (See §4408.8.)

61 Comprehensive Inpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65 End Stage Renal Disease Treatment Facility - A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

71 State or Local Public Health Clinic - A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic - A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

81 Independent Laboratory - A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician s office.

99 Other Unlisted Facility

Medicare Web Site Information

FREE MEDICARE TRAINING COURSES!

The Health Care Financing Administration (HCFA), now offers a free Medicare On-line Training Web Site (www.medicaretraining.com), designed to capitalize on the emerging Internet-based training market. Users can access the site to download free Medicare computer based training (CBT) courses that help them develop their Medicare billing skills and knowledge.

Visit the www.medicaretraining.com web site for our free Medicare courses.

Each course is national in scope. CBT users can apply what they learn, no matter where they are from. Courses currently available include:

1. ICD-9-CM Coding
2. Front Office Management
3. HCFA-1500 Claims Filing
4. HCFA-1450 (UB92) Claims Filing
5. Medicare Fraud & Abuse
6. Medicare Home Health Benefit
7. Introduction to the World of Medicare
8. Medicare Secondary Payer
9. Adult Immunization
10. Women's Health

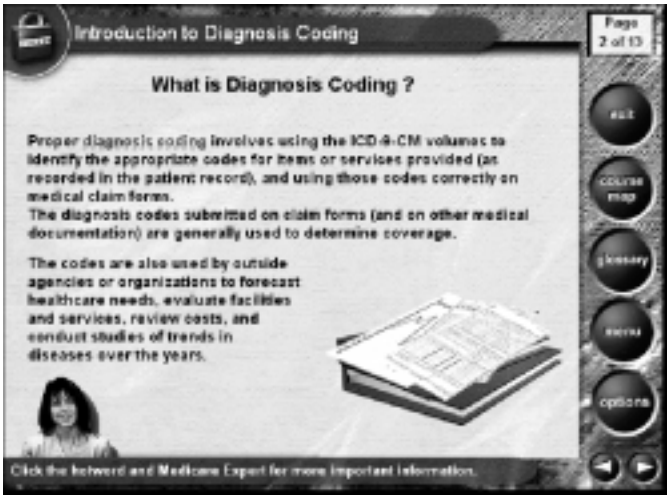
Here's how it works:

Users visit the Medicare On-line Training web site at www.medicaretraining.com and click on "Computer Based Training" to download the course(s) of their choice. Once a course is downloaded and installed on a PC, users are then able to take the courses at their leisure. The site provides complete step-by-step instructions on how to download and set up the courses.

System Requirements:

- **Windows 95, 98 or NT**
- **mouse**
- **VGA color monitor**

CBT offers users the flexibility to have control over their learning environment. In every course, users are given the opportunity to practice what they've learned through quizzes and tests. After each test is taken, users are given full access to their results, instantly. Users may take as long as they want to complete each lesson, and they can take them as often as they like.



Above is an example of the ICD-9-CM computer based training course.

The Medicare On-line Training Web Site gives Medicare yet another channel to reach new audiences and deliver consistent, up-to-date materials and services. To date, over 114,000 courses have been downloaded. HCFA welcomes your participation in this overwhelmingly successful program.

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